12-2006

Psychosocial Adjustment Among Refugee Children

Nola Ivana Lawrence

LOMA LINDA UNIVERSITY
School of Science and Technology
in conjunction with the
Faculty of Graduate Studies

Psychosocial Adjustment Among Refugee Children

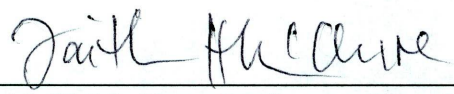
by

Nola Ivana Lawrence

A Dissertation submitted in partial satisfaction of
the requirements for the degree of
Doctor of Psychology

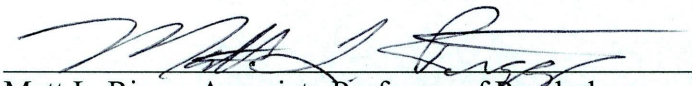
December 2006

Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree of Doctor of Psychology.

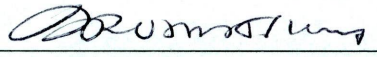


, Chairperson

Faith H. McClure, Professor of Psychology



Matt L. Riggs, Associate Professor of Psychology



Emmanuel Rudatsikira, Assistant Professor of Global Health and Epidemiology and Biostatistics

ACKNOWLEDGEMENTS

I am most grateful to God for His grace, mercy, and love as He has sustained me through this dissertation process and doctoral program. I would like to express my appreciation to the Loma Linda University Department of Psychology and faculty for the solid educational base and support given in this doctoral program turned marathon. I wish to thank the members of my dissertation committee, Faith H. McClure, Ph.D., Matt L. Riggs, Ph.D., and Emmanuel Rudatsikira, MD, M.P.H. for their guidance and endurance throughout this "gestational period" known as the dissertation process, and the contributions they made from their theoretical and clinical base buttressing my own. I am also grateful to Bethel Seventh-day Adventist Church, the Black Alumni of Loma Linda and La Sierra Universities (BALL), the North American Division of Seventh-day Adventists Regional Office for the Regional Scholarship, the North American Division of Seventh-day Adventists Hispanic Ministry for the Hispanic Scholarship Fund, the Southern California Conference of Seventh-day Adventists, the Southeastern California Conference of Seventh-day Adventists, the Society for the Psychological Study of Social Issues for the Applied Social Issues Internship Program Award, and the All Nations African Seventh-day Adventist Church for making financial contributions toward the completion of my dissertation and graduate training.

DEDICATION

In honor of the Creator God, the One True God, who was and is and is to come, and who has brought me to a place of conceding my will and refining my character, I dedicate this work. In praise and thanksgiving, I raise this accomplishment and celebrate the works of the Trinity in my life, and in whose wisdom, love, grace, and power, my life has been blessed with phenomenal supporters who have been edifying. . .

- My maternal grandparents, Mr. and Mrs. Cecil and Margaret Lumbsden, who passed on a spiritual legacy I value more than money.
- My mother, Mrs. Minna B. Lawrence, whose unwavering prayers have carried me over mountains, through valleys, and across deserts.
- My uncles and aunts, Samuel "Tío Sam" and Estela Lumbsden, Steadman "Tío Steadman" Lumbsden, Cecil "Tío Cecil" Lumbsden, Clarita "Tía Clara" Lumbsden, Elsa "Tía Elsa" Lumbsden, Edna "Tía Adams" Adams, Leola "Aunty Lee" Denham, and Junelle "Aunty Vance" Vance; who are fierce and undaunted in their commitment to support "the younger ones."
- My siblings, Jon and Estefania "Stephy" Howell, Lanny "Lan" Lawrence, A. Rolando "Roly" and Donette Lawrence Lumbsden, the Howell Clan - Janet, Jarvis, and Jaccie; Cousins, Mirza "Chula Vista" Lumbsden, Alvin "Primo" Walden, O. Fernando "Nando" Walden (deceased), and Deorla "Dee" Davy, and extended family for planting trees of encouragement with deep and thick roots.
- My nephews and nieces, Jonathan "Jon" Howell, Janelle "Janelly" Howell, Jacquelyn "Jacq" Austin L., and Dominic "Dominicolas" Lawrence Avery; whose presence is a source of inspiration and growth.

- My friends, whose support has "held up my hands" on countless occasions.
- AfricaCorps (Mid-City Community Project) and Cultural Brokers, Agnes Hassan, Galwak Deng (Executive Director), and John Kang, without whose connection with the Sudanese community this dissertation would not exists.
- The late John Kang, Cultural Broker, who worked tirelessly and passed away before the conclusion of this research project.
- The Sudanese community for being willing to open their hearts and lives to a stranger, so we may all learn how to better serve the needs of refugee families.
- "My community" who challenged me to endure to the end, Pomona Seventh-day Adventist Church (Pomona, CA), Bethel Seventh-day Adventist Church (Pomona, CA), Oakwood College (Huntsville, AL), All Nations African Seventh-day Adventist Church (San Bernardino, CA), Otto "Buddy" Keubler, IV and the Daniells Hall Family at Loma Linda University, Daphne Rowe, and Irwan Rosadi.
- Those who brought professional and/or personal support in the areas of statistics, data collection, and/or data entry assistance, Olufunke Victoria Ayoola, Tope Ogunrinu, George Marcoulides, V. Diane Woods, Tenesha Berry, Hosue M. Ramirez A., Theresa Alexander, Lloyd Sealey, Jr., Carolyn Sallion, and Sandra Brooks.
- Professionals who gave stellar examples of how to treat the "unknown graduate student" as they received my emails and calls (locally, nationally and internationally), and gracefully agreed to share their instruments and research results with me.

CONTENTS

TABLES

Table

ABBREVIATIONS

BALL	Black Alumni of Loma Linda and La Sierra Universities
HSCL – 25	Hopkins Symptom Checklists – 25
ICS	Interpersonal Competence Scale
PSOC	Parenting Sense of Competence Scale

ABSTRACT OF THE DISSERTATION

Psychosocial Adjustment Among Refugee Children

by

Nola Ivana Lawrence

Doctor of Psychology, Graduate Program in Clinical Psychology
Loma Linda University, December 2006
Dr. Faith H. McClure, Chairperson

Refugee children are faced with multiple stressors. These stressors include unresolved issues with country of origin, transition to a new country, and long-term adjustment. War is a traumatic situation. For children who have gone through the trauma of war, parents may contribute one of the major influences to their psychosocial adjustment. The purpose of this study was to assess the role that parental mental health, as measured by the Hopkins Symptom Checklist – 25 (HSCL-25) and parenting sense of competence as measured by the Parenting Sense of Competence Scale (PSOC), plays in children's psychosocial adjustment to war trauma using delinquency as measured by the Delinquency Behavior Measure and interpersonal competence as measured by the Interpersonal Competence Scale (ICS) as outcome measures. Sixty-eight Sudanese refugee families were evaluated. The parents were asked to fill out the HSCL-25 and the PSOC, and their children were asked to fill out the Delinquency Behavior Measure (subscale I), and the Interpersonal Competence Scale. Correlations and multiple regressions were run on the data. The results of the current study indicated that good parental mental health was associated with good interpersonal competence in refugee children. Further, that there was an association between parental sense of competence

and children's interpersonal competence. However, although these associations existed, one did not necessarily explain the other. No relationship was found between children's delinquent acting out and parents' mental health or sense of competence. The results suggested that while parental factors impact refugee children's adjustment, parental mental health and sense of competence may not be the biggest predictors of children's interpersonal and prosocial/antisocial outcomes.

Children and War

The Impact of War

War impacts the lives of children. It changes the course of events in the children's lives by disrupting and/or eliminating the stability that existed. The disruption is evidenced in several different ways. The home may be transformed from order to chaos. Parents' and/or other family members may be absent due to imprisonment or death. The community in which they live may also show signs of the conflict. The infrastructure and its accompanying buildings may be converted for other uses or destroyed. The children's daily routine stops focusing on recreation and academics, and begins to focus merely on survival. The effects of war on children are both indirect and direct (Ladd & Cairns, 1996; Paardekooper, de Jong & Hermanns, 1999; Berman, 2001; Ajdukovic & Ajdukovic, 1998). In other words, the children may be direct recipients of shellings, bombings, or torture. Or, the children may be indirect recipients by learning of family members, friends, or neighbors who have been tortured, murdered, or displaced from their homes.

The changes experienced by these children are not only evident in their physical environment, but also in their psychological worlds. Children who have been happy and well-adjusted become fearful, depressed and reactive due to the experience of war. Children are not exempt from the negative impact of war on their mental health (Walton, Nuttall & Nuttall, 1997; Tobin, 2000; Rousseau, Drapeau & Platt, 1999; Mollica, Poole, Son, Murray & Tor, 1997; Mghir & Raskin, 1999). Children experience symptoms such as confusing fantasy with reality, poor concentration, poor memory, high dependency,

nightmares or sleep problems, worries about bad memories, and become extremely emotional (Walton, Nuttall & Nuttall, 1997). All of these symptoms are indicative of how a child's mental health is impacted by war.

The single most important effort of parenting is to establish and maintain structure and stability in a warm and caring way. War often thwarts parental efforts to establish and maintain structure, routines, and stability in a nurturing way. During war, children face very mature issues such as dealing with injury, hate, death, torture, and survival. Children may see people, including their family members, being hurt, tortured, raped, mutilated, shot, blown up, or killed. They may also experience this treatment or have to commit these acts (Derluyn, Broekaert, Schuyten, & De Temmerman, 2004). Furthermore, many countries employ and retain children as soldiers to fight in their wars (Baker & Shalhoub-Kevorkian, 1999; Shaw, 2003; Pearn, 2003; Boyden, 2003; de Silva, Hobbs, & Hanks, 2001; Mendelsohn & Straker, 1998). Therefore, children take a quantum leap into adulthood without being prepared to do so and the impact has various psychological repercussions. Interestingly, the impact of these events may results in adaptive or maladaptive outcomes. For some children, they act out or become anxious, others lose hope and live for the moment, and yet others strengthen their resolve to survive and thrive (Baker & Shalhoub-Kevorkian, 1999). Regardless of the reaction, children discover that they need to adjust.

Factors Facilitating Good Adjustment

The question becomes, what factors facilitate good adjustment for children who have experienced war? Although there exists some differences between children who

have experienced war and those who live in communities where there's violence – gang or otherwise, the interventions used to facilitate good outcomes are most likely transferable. In general, a structured, consistent, warm, and growth-producing environment is necessary. This may be provided by the parent or by the involvement of any "positive adult role model" (Lale, 1992, p. 280). The consistent guidance and association with an adult other than a parent who is genuinely interested in the development of the child has been shown to have positive results (Lale, 1992). The time spent in extracurricular activities such as sports and clubs may serve as an outlet for pent up energy as well as an opportunity for social interaction. Extracurricular activities provide an opportunity where mastery can be attained, and appropriate social interaction can be developed within the framework of a structured environment. One of the developmental tasks of children is mastery; mastery of skills, social interaction, and of self. Parenting factors also foster good adjustment. For example, Appleyard & Osofsky (2003) posit that the parents' mental health and ability to be emotionally responsive impact the children's adjustment to traumatic circumstances in life. It is logical for children to rely on their parents' support, stability, security, and love specifically when stability and security are being challenged by the circumstances in their environment. The entire range of characteristics and skills possessed by the parents as well as their sense of competence has the potential to be correlated with good adjustment for children during these times.

Adjustment Outcomes

There are various outcomes that may be used to determine adjustment to the war experience. However, this study will focus on delinquent behavior and interpersonal competence. Both of these constructs provide the opportunity to determine the child's level of psychosocial adjustment. Delinquent acts by children are often an indication that they are psychologically overwhelmed. The reasons vary from lack of caring and structure to abuse and pain. The probability that psychologically well-adjusted children will commit delinquent acts is low (Achenbach & Edelbrock, 1981). It is a well-established fact that children having difficulty with adjustment are more inclined to be involved in delinquent behavior (Achenbach & Edelbrock, 1981). Delinquent behavior is an attack on society. Responsible adults desire for their offspring to grow to contribute to society, not destroy it. Delinquent behavior is a maladaptive response.

Adjustment can include personal, academic, social, and emotional adjustment. For this study, adjustment is also restricted to the interpersonal competence of the child at school and/or at home. It is the construct that taps into how a child relates with his/her teachers, peers, parents, and siblings. This measurement of interpersonal competence highlights how well the child's social skills have been developed, and to what degree the war experiences have had an impact on the child's interpersonal well-being. Healthy interpersonal relationships partially comprise psychological health, since humans are social beings. They assist in the adjustment process and contribute to positive outcomes after difficult situations have occurred. War trauma can hinder a child's ability to trust, and in this way can hinder the development of healthy interpersonal interaction. Therefore, the measurement of interpersonal competence will help us understand the

presence and degree of war trauma, its impact, and how the child is adjusting interpersonally.

Parenting Factors Impacting Children's Adjustment

Among those named, parenting factors have one of the greatest positive influences on a child's psychosocial adjustment to war. The support, warmth, and structure parents offer may serve as a buffer against some of the negative outcomes that arise from war experiences. Parents possessing stability will provide for their children the consistency and stability they will need to cope with the chaos and instability that occurs during war. The sense of dissatisfaction with and incompetence in their parenting role may contribute to some of the negative outcomes. That is, parents who experience the role of parenting as frustrating and anxiety provoking and who have minimal problem-solving skills and efficacy in this role, will be unable to help their children cope with the additional adjustment demands that occur due to war. When a lack of a sense of competence is combined with poor psychological health in the parents, children's outcomes are even more negatively impacted. When parent-child attachment, parental emotional availability, and parental ability to provide consistency, nurturance, and structure is greatly challenged, it leaves children to find their own solutions under the very difficult circumstances that war brings about. This further implies that the presence or absence of certain parental skills and emotional states have an impact on the children's adjustments.

Children with Other Traumas

Parents impact children. In society, parents are the main conduit for passing on ideologies and behaviors, progressive or destructive. One well-known study by Bandura, Ross & Ross (1961) showed that children imitated the violent and aggressive behavior of an adult model in the room. Often, the model did not interact with the child; the child simply observed the aggressive behavior and imitated it. Studies have documented that the children imitated the adults' behavior whether or not the adult was the parent (Bandura, Ross & Ross, 1961; Gerull & Rapee, 2002). Furthermore, if a child imitated a model, how much more would the child imitate the parent or guardian? We know that children frequently adopt parental ideas and attitudes (Jackson, 1999). Children's observation of their parents' cognitive processing, psychological health, emotional availability, and parenting practices also influence their adaptation to their life experiences. In the literature on child sexual abuse, one of the most defining markers that determine the impact the abuse has on the child is maternal support (Kendall-Tackett, Williams, & Finkelhor, 1993). Maternal support is defined as "believing in the child and acting in a protective way toward the child" (Kendall-Tackett, Williams, & Finkelhor, 1993, p. 172). It is well known that children observing domestic violence in the home have a higher probability of being either the victim or perpetrator upon reaching adulthood (Wolfe & Korsch, 1994). This literature on the children's psychosocial adjustment being impacted by factors related to the parents is significant. Thus, parental psychological well-being and their parenting efficacy will have great impact on

children's behavior and interpersonal interaction. The many dimensions of a parent can impact the child in various ways either in the present and/or in the future.

Dimensions of Parenting Factors

Parental mental health. A parent's mental health status potentially contributes to the child's mental health including psychosocial functioning. One well-quoted study indicates that children of depressed mothers are at a high risk for depression (Burge & Hammen, 1991). This risk is influenced not only by biological risks, but also by emotional availability, modeling of coping, and parenting practices presented by the parent (Burge & Hammen, 1991). A longitudinal study assessing maternal mental and medical health also supported the findings that these risks were found in various outcomes related to the children's psychosocial functioning including behavior problems, social competence, academic performance, and school behavior (Anderson & Hammen, 1993). Furthermore, these results were stable over time and more significant when the mothers had been diagnosed with unipolar depression, as opposed to bipolar disorder, a medical illness, or were psychiatrically and medically normal (Anderson & Hammen, 1993). Interestingly, children of depressed mothers have been found to have extraordinarily high exposure levels to stressors (Adrian & Hammen, 1993). The types of stressors were categorized as both "episodic and chronic" (Adrian & Hammen, 1993, p. 358). The implications cover both temporal and psychological conditions. In other words, children of depressed mothers withstand extremely high levels of stressors over a long time which drastically increases the occurrence of depression. This suggests that when parents have low psychological well-being, they are less likely to buffer their

children from stressors. Under conditions of war, the lack of buffering might have even more detrimental outcomes for children.

The findings that maternal mental health status impacts the child's mental health status are many (Hammen, Burge, & Stansbury, 1990; Burge & Hammen, 1991; Anderson & Hammen, 1993); however, the exploration of paternal psychopathology has only recently begun. Paternal psychopathology is also crucial. In fact, the cumulative effect of maternal and paternal psychopathology is important. Brennan, Hammen, Katz, & Le Brocque (2002), found that paternal depression and paternal substance abuse strengthened the relationship between maternal depression and the presence of depression in their children. The results further indicated that maternal depression and paternal substance abuse greatly increased the probability of the children becoming depressed (Brennan, Hammen, Katz, & Le Brocque (2002). The summary remains consistent; a relationship between parental mental health and children's psychosocial functioning exists. When there is parental psychopathology, its deleterious effect has been observed to consistently impact the children over time, and drastically increase the probability that they will also have poor mental health.

Parenting sense of competence. Among the factors related to parental mental health, the parents' sense of efficacy and satisfaction with their parenting is also important. This issue of parental sense of competence, which includes a combination of the parents' affective and instrumental dimensions in the parenting role, is also likely to impact the children. When parents lack satisfaction and efficacy in their parenting, problems are likely to arise. Satisfaction is the affective component in parental competence. This area focuses on the feelings of anxiety, frustration, and the degree of

motivation the parent's possess (Johnston & Mash, 1989). Efficacy refers to parents' problem-solving ability, capability, and competence possessed, i.e., the instrumental dimension in parenting (Johnston & Mash, 1989). Research suggests that parents who possess a higher sense of efficacy also possess a more effective level of involvement with their children (Swick & Broadway, 1997). In the rearing of children, involvement is crucial. The more effective the involvement, the more effective the help children receive, and the better the probability of healthy adjustment. The healthier the adjustment, the less likely it is that the children will be involved in delinquent behavior and the more likely it is that they will be socially competent. For example, parental efficacy has been found to greatly impact the development of social competence in two, three, four, and five-year-old children in a preschool setting (Swick & Hassell, 1990).

Integrating parenting factors with children's outcomes. The combination of parental mental health and parenting sense of competence are believed to be important factors that influence the psychological adjustment of children who have experienced war. For this study, the outcomes used to determine the child's psychosocial adjustment include delinquent behavior and interpersonal competence.

Parents provide stability, warmth, care, and structure for children. The parents' mental health influences the degree to which these items are provided. Parental mental health is significant for from it springs both the affective and cognitive basis of the parents' reactions and actions. This area may also impact the sense of competence parents possess regarding their parenting role. It may be one of the major influential factors in whether the parent's level of anxiety will rise so high that problem-solving capabilities decrease drastically. Conversely, good parental mental health may be one of

the primary factors that contribute to low levels of frustration, ability to provide structure and warmth, and a higher sense of competence in his/her parental role. Whether negative or positive, parental factors impact the outcomes observed in a child's psychosocial adjustment after war. The more mentally stable and secure the parents, the more likely it is that the child will not engage in delinquent behaviors and will demonstrate more positive interpersonal competence.

Summary

War disrupts the stability in children's lives. The disruption is evident in all areas of their lives. Children may lose the adult members of their family, or may themselves be witnesses of the atrocities of war. Then, children may have to abandon their age-appropriate developmental tasks, thus interrupting the normal maturational process. The children's world takes on more adult themes. Children who have experienced war demonstrate various responses, some of which are adaptive and others, maladaptive. The responses demonstrated offer an indication as to the psychosocial adjustment of children who have experienced war. The outcomes that will be the focus of this study are delinquent behavior and interpersonal competence.

Delinquent behavior may serve as an indicator of poor psychosocial adjustment. It usually points to a psychosocial system that is overwhelmed. Delinquent behaviors or responses represent an attack on society. Children with fewer delinquent behaviors are judged as possessing better levels of psychosocial adjustment.

This attack on society represented by the delinquent behavior is significant, since humans are social beings. In addition to assessing delinquent behavior in general, it is

also important to assess children's adjustment in reference to their social environment and competence. The assessment of children and adolescents' social development is an indicator of interpersonal competence. It assesses the extent to which children can appropriately engage in social/interpersonal relationships with peers, family, and teachers. Clearly, a child with better interpersonal competence is most likely to be judged to possess better psychosocial adjustment.

Parenting factors impact the children's psychosocial adjustment. This study will focus on two such factors, mental health and parenting sense of competence. Parental mental health is part of the framework that provides stability and structure for children. These constructs – stability and structure, are even more significant and needed when a trauma, such as war, has occurred. Poor parental mental health would contribute negatively in an environment where structure and stability are necessary for the psychosocial adjustment of children and would lead to poorer child outcomes. The same principle would apply for parenting sense of competence. This construct assesses the satisfaction and efficacy of parents in their parenting role. The presence of frustration and/or anxiety may obstruct a parent's ability to implement good problem-solving skills. The existence of these factors, coupled with poor mental health, may foster an environment that thwarts psychosocial adjustment in children.

Hypothesis

The purpose of the proposed study is to determine the impact of parenting factors, specifically, parental mental health and parenting sense of competence on children who have experienced war. The specific psychosocial adjustment outcomes evaluated in this

study include delinquent behavior and interpersonal competence. Previous research suggests that parental responses are the major determinants of outcomes in children who have been traumatized. Kendall-Tackett, Williams, & Finkelhor (1993), for example, note that outcomes for children who have been sexually abused are determined primarily by the parents' response when they discover that their child has been abused. In addition, parental psychological state or mental health also impacts children's outcomes. For example, Anderson & Hammen (1993) found that children whose mothers are depressed are also known to be at high risk for problems in their psychosocial functioning. Paternal depression and substance abuse was found to strengthen association of children's outcomes of depression with maternal depression (Brennan, Hammen, Katz, & Le Brocque, 2002). These findings suggest that parents impact the psychosocial adjustment of their children. Therefore, it is hypothesized that parental mental health and parenting sense of competence will impact refugee children's interpersonal competence and delinquent behaviors, specifically in the following manner:

1) (a) There exists a negative correlation between parental mental health, as measured by Hopkins Symptom Checklist-25 (HSCL-25) (Derogatis, Lipman, Rickels, Uhlenhuth & Covi, 1974) and children's interpersonal competence, as measured by Interpersonal Competence Scale (ICS) (Cairns, Leung, Gest, & Cairns, 1995). That is, low scores, or good mental health, will be associated with high scores, or good interpersonal competence.

   (b) There exists a positive correlation between parenting sense of competence as measured by the Parenting Sense of Competence Scale (PSOC) (Johnston &

Mash, 1989), and children's interpersonal competence as measured by Interpersonal Competence Scale (ICS-P) (Cairns, Leung, Gest, & Cairns, 1995).

(c) Parental mental health will predict children's interpersonal competence and will account for a significant amount of the variance in this child outcome. Parenting sense of competence will explain additional variance beyond that explained by parental mental health.

2) (a) There exists a positive correlation between parental mental health, as measured by Hopkins Symptom Checklist-25 (HSCL-25) (Derogatis, Lipman, Rickels, Uhlenhuth & Covi, 1974) and children's delinquent behavior, as measured by the Delinquent Behavior Measure (Peacock, McClure & Agars, 2003). That is, high scores, or poor parental mental health will be associated with high scores, or delinquent behavior.

(b) There exists a negative correlation between parenting sense of competence as measured by the Parenting Sense of Competence Scale (PSOC) (Johnston & Mash, 1989), and delinquent behavior as measured by the Delinquent Behavior Measure (Peacock, McClure & Agars, 2003). That is, high scores, or good parental sense of competence will be associated with low scores, or fewer delinquent behaviors.

(c) Parental mental health will predict children's delinquent behavior and will account for a significant amount of the variance in this child outcome. Parenting sense of competence will explain additional variance beyond that explained by parental mental health.

Methodology

Participants

The subjects in this study were volunteers from the clientele of AfricaCorps (later renamed, Mid-City Community Project) in San Diego, California, an organization formed by Galwak Deng, Executive Director, to assist immigrant and refugee persons. They were also recruited from the Sudanese community at large. The participants were 68 Sudanese refugee families who had experienced war trauma. They currently reside in San Diego County in California and have lived in the United States ranging from four months to 15 years. The persons interviewed in each family were composed of at least one parent (father and/or mother, male and/or female guardian) and one child/adolescent. The children/adolescents who are part of the foster care system or those who are not in legal guardianship of parents or guardians were not selected. They ranged in age from 9 to 19 with data missing on 2 (2.9%) children and the mean age was 13.89 (SD = 2.17). The number of families with both parents was 45 (66.2%), the number of families with fathers only was 7 (10.3%), and the number of families with mothers only was 16 (23.5%). The number of boys and girls who participated in the study were 33 (48.5%) and 32 (47.1%), respectively, with data missing on the gender of three children. Families were interviewed in Arabic and for those who did not speak Arabic, local Sudanese languages were used. Procedures were established that would necessitate the Cultural Brokers interviewing the families in Arabic, but while in the field it was discovered that it was also necessary to utilize several local Sudanese languages. These details can be found in Appendix Q. Most of the families came from low socioeconomic backgrounds

based on the fact that 75% of the children reported receiving free or reduced lunch; see Appendix R for further details. When asked how traumatic their displacement was on a likert scale of 1 to 7 (1 = Least and 7 = Most), 32 (47.1%) fathers indicated that it was most traumatic with 19 (27.9%) refraining from answering, and 2 (2.9%) stating least traumatic. The mean response was 6.37 (SD = 1.29). Of the mothers, 36 (52.9%) indicated that it was most traumatic with 10 (14.7%) refraining from answering. The mean response was 6.45 (SD = 0.84). Of the children, 30 (44.1%) indicated that it was most traumatic while 3 (4.4%) refrained from answering, and 2 (2.9%) indicated that it was least traumatic. The mean response was 5.75 (SD = 1.63). These details can be found in Appendix S and Tables 3-5.

Instruments

The instruments which were used in this study included (a) Personal Data Sheet, (b) Hopkins Symptom Checklist – 25 (HSCL-25), (c) Parenting Sense of Competence (PSOC), (d) Interpersonal Competence Scale (ICS), and (e) Delinquent Behavior Measure [see Appendices K-O].

Personal Data Sheet. Participants will complete questions related to their age, gender, country of origin/birth for the parent/guardian, ethnicity, languages spoken, languages written, total number of years spent outside of the country of origin/birth due to the war, the names of the countries and duration of time related to displacement, a 7-point likert scale asking to rate how traumatic the displacement has been, the indication as to the family's socioeconomic status based on whether they qualify for the national school lunch program, the number of persons living in their household, parents' present

occupation, parents' highest educational level, children/adolescents' grade in school, and an indication as to who the children live with [see Appendix K].

Hopkins Symptom Checklist-25 (HSCL-25). The HSCL is a 25-item version of the 58-item Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth & Covi, 1974). It is a self-report scale designed to measure outpatient psychiatric symptoms. The HSCL-25 assesses anxiety, depression, and somatic symptoms; ten, thirteen, and two items, respectively (Mollica, Wyshak, de Marneffe, Khoun & Lavelle, 1987). It is an instrument which has been translated into various languages for both refugees and immigrants (Kleijn, Hovens & Rodenburg, 2001). Respondents rate themselves on each item using a four-point likert scale (1=Not at all to 4=Extremely). Respondents answer how much that problem has distressed or bothered them during the past 7 days including the day the questionnaire is being completed. The score ranges from 1 to 4 for each item. High scores indicate high levels of symptom distress; the reverse is true for low scores. The internal consistency reliability scores were high, ranging from .8 and .9 for the different scales and language translations (Kleijn, Hovens & Rodenburg, 2001). For this study, the overall score will be used to determine each subject's mental health score [see Appendix L].

Parenting Sense of Competence (PSOC). The PSOC is 16-item scale designed by Johnston & Mash (1989) to measure parenting self-esteem. Parenting self-esteem assesses the parents affective, behavioral, and functioning levels. The PSOC is composed of two factors: Satisfaction, an affective dimension measuring "parenting frustration, anxiety, and motivation"; and an instrumental dimension assessing "competence, problem-solving ability, and capability in the parenting role" (Johnston &

Mash, 1989, p. 167). It was designed to reflect parenting self-esteem (satisfaction and efficacy) (Johnston & Mash, 1989). Respondents use a 6-point likert scale (1= Strongly agree (SA) to 6=Strongly Disagree (SD)) to indicate whether they agree or disagree with a particular statement (e.g., Being a parent is manageable, and any problems are easily solved). The scores could range from 1 to 6 for each item. Scores for each scale are obtained by summing the responses to the items, and the total from each scale is combined to acquire the total score for parenting sense of competence. For the Satisfaction Scale, disagreeing indicates more satisfaction; and for the Efficacy Scale, agreeing indicates greater efficacy. The internal consistency reliability (Cronbach's alpha coefficients) for the total score is alpha of .79 (Johnston & Mash, 1989). The overall score will be used to determine parenting sense of competence [see Appendix M].

Interpersonal Competence Scale. The ICS was designed by Cairns, Leung, Gest, & Cairns (1995) to assess social and behavioral development in children and adolescents. It is composed of 18 items and "each item is presented as a unidimensional, 7-point scale" (Cairns, Leung, Gest, & Cairns, 1995, p. 726). Informants are asked to fill in the box that best describes themselves on each item, with one end indicating "never," the midpoint indicating "sometimes," and the other end indicating "always." "The descriptors describe the points of the scale at the extremes and at the mid-point. To avoid response bias, the extremes are reversed so that the socially desirable alternatives (when these can be identified) occur on both the left and right extremes of the items" (Cairns, Leung, Gest, & Cairns, 1995, p. 726). The possible scores for each item range from 1 to 7. The general rule for scoring is that the higher the score for each item, the more descriptive it is of the subject. The internal consistency reliability (Cronbach's alpha coefficients) scores were

acceptable, and ranged from 0.67 to 0.84. The overall score will be used to determine the child's level of interpersonal competence [see Appendix N].

Delinquent Behavior Measure. The Delinquent Behavior Measure is a 84-item self-report questionnaire designed by Peacock, McClure, & Agars (2003) to assess the type, occurrence, and frequency of delinquent acts committed by children in response to the stress they encounter in their community, at school, or at home. It was designed for a middle school/junior high population. These behaviors include assessing for "violent behavior, violent thoughts, substance use, and general delinquent behaviors" (Peacock, McClure, & Agars, 2003, p.63 & 64). Respondents use a 5-point Likert scale (1=Almost Always or Always true to 5=Almost never or never true) to indicate the type, occurrence, and frequency of the delinquent acts (e.g., stealing, vandalism) they are committing or contemplating. There are two subscales, Behavior I and Behavior II; the first acquires information on the behaviors that have been committed and their frequency, and the second acquires information on the behaviors the children have thought about doing and their frequency. For this study, actual behaviors committed will be used; subscale Behavior I. Each subscale is composed of 42 questions, and there exists four dimensions; violent thoughts, violent behavior, substance abuse, and general delinquency. The scores range from 1 to 5 for each item. Scores for each scale are obtained by summing the responses to the items, and the total from each scale is combined to acquire the total score for delinquent acts committed or contemplated. High scores indicate high levels of involvement in these acts; the reverse is true for low scores. The alpha coefficient was 0.92 (Peacock, McClure, & Agars, 2003). The overall delinquency score will be used in this study [see Appendix O].

Procedures

In completing this study, contact was made with the Executive Director of AfricaCorps (later renamed Mid-City Community Project), Galwak Deng, a center serving refugee and immigrant families. A letter of support was acquired indicating his support [see Appendix A]. Mr. Deng was not directly involved in the recruitment process; however, he did facilitate the process. He facilitated the completion of the study by: 1) Referring the two individuals who worked as Cultural Brokers for the study, 2) Introducing the basic information about the study to the Cultural Brokers, 3) Introducing basic information about the study, the Researcher, and the Cultural Brokers to the Community Leaders at the community meetings, 4) Introducing the study, Researchers, and the Cultural Brokers at the churches, 5) Allowing the placement of flyers at AfricaCorps (Mid-City Community Project) [see Appendix F], and 6) Asking his staff to inform the clientele about the study. The interest cards were not used by the Cultural Brokers in recruiting subjects for the study, although this was part of the original recruitment strategy [see Appendix H]. The individuals who were referred as Cultural Brokers for the study worked as Outreach Workers for other agencies, and therefore had the necessary experience to be Cultural Brokers.

The subjects were drawn from the population of Sudanese families who have all experienced war, have sought refugee status from the United States government, live in San Diego, California, and speak Arabic. Subjects were invited to participate via flyers and numerous verbal announcements made in the churches that they frequented [see Appendix F and G]. The Sudanese population had also set up monthly community meetings and this study was announced there as another recruitment method. Those

willing to volunteer for the study were contacted by one of the Cultural Brokers. The families were initially supposed to fill out interest cards, but in the field this system was not successful [see Appendix H]. The Executive Director and his staff also informed clients at the center regarding this study and the clients were given the option of participating.

All of the forms and questionnaires, with the exception of two questionnaires, were translated into Arabic, the languages spoken by the participants and Cultural Brokers. The process of translation included the translation from English to Arabic. Then, using the translated Arabic document, these questionnaires were translated back to English. In order to establish the document as a valid translation, the personnel translating from English to Arabic did not translate the questionnaires from Arabic back to English. Due to the children's fluency with English, the Delinquent Behavior Measure and the Interpersonal Competence Scale were not translated into Arabic. The four questionnaires are: Delinquent Behavior Measure, Interpersonal Competence Scale (ICS), Parenting Sense of Competence Scale (PSOC), and Hopkins Symptom Checklist-25 (HSCL-25). Referrals were received from the Executive Director as to individuals who would be qualified to serve as Cultural Brokers for the study. Meetings were held with the purpose of introducing the researcher, interviewing the Cultural Brokers, introducing the study, providing training to the Cultural Brokers as it related to general as well as specific ethical guidelines, and instructing the Cultural Brokers in the appropriate procedures to be followed in order for the results to demonstrate validity and reliability. The participants completed the necessary consent forms [see Appendix I and Appendix J] with assistance from the Cultural Brokers; an informed consent form was completed by

the parents [see Appendix I] and an assent form for the minors ages 9-12 [Appendix J]. The children ages 13-18 completed the consent form and their parents also gave written consent [see Appendix I]. The study's participants only included children who live with their father and/or mother, or a male and/or female guardian; children who were part of the foster care system or were not in legal guardianship of parents or guardians were not selected. In addition to completing the appropriate consent and assent forms as well as the questionnaires, a Cultural Broker also relayed the information on the debriefing statement [see Appendix P]. All participating families were given $10, and the study was completed in each family's home. In each family a father and/or mother, male and/or female guardian, and one child were interviewed.

The parents completed the Hopkins Symptom Checklist-25 (HSCL-25) [Appendix L] and the Parenting Sense of Competence (PSOC) [Appendix M]. The children/adolescents completed the Interpersonal Competence Scale (ICS) [see Appendix N] and the Delinquent Behavior Measure [Appendix O]. The Personal Data Sheet was completed by both the parent (s) and children [see Appendix K]. A copy of all four questionnaires in English will be placed in the corresponding appendices.

Training was given to the Cultural brokers in accordance with ethical guidelines – The Belmont Report, that needed to be followed as well as the appropriate procedures necessary for this study [see Appendix B-E]. Cultural Brokers were to have read the questionnaires to the participants in Arabic so as to assist in the completion of the study and establish reliability, but due to the lack of Arabic literacy, the questionnaires were translated 'in vivo.' Upon arrival, the Cultural Brokers established rapport with the family, explained the study and its procedures, and interviewed the family members.

Informed consent/assent was completed first, followed by the personal data sheet, the questionnaires, and the debriefing statement. Since the children had two questionnaires to complete, they were completed during the time the parents were completing their questionnaires. The families who completed the entire packet were given a $10 gratuity. To establish anonymity and confidentiality during data collection, each family was assigned a letter of the alphabet and each participating family member a number. For example, the Law Family would be assigned the letter A, the father will be A1, the mother will be A2, and the child will be A3. As there were 68 families, the letters doubled or tripled as necessary. For example, the Hal Family would be assigned the letters AA, the father will be AA1, the mother will be AA2, and the child will be AA3. The Stead Family was assigned the letters AAA, the father will be AAA1, the mother will be AAA2, and the child will be AAA3. A record matching the names with letters and numbers was not kept.

Due to the sensitivity of the subject matter, the debriefing process included a debriefing statement and the names of the agencies to which the participants can be referred [see Appendix P]. A copy of the findings was to have been placed at AfricaCorps (Mid-City Community Project) for their permanent records as well as for the study's participants' viewing pleasure; however, the organization no longer exists and the Executive Director, G. Galwak Deng, has since returned to Sudan. Mr. Deng is believed to be currently serving as a government official in the Republic of Sudan. A copy of the dissertation will be given to St. Luke's Refugee Network which is associated with the St. Luke's Episcopal Church in San Diego, CA. This is due to the fact that a large percentage of the Sudanese community is associated with either or both of these

organizations. The Cultural Brokers were given an honorarium for their participation in the study.

Results

Data Screening

Means, standard deviations, and bivariate correlations for all study variables are presented in Table 1. Prior to conducting the primary analyses, data were screened for out-of-range values, missing data, and violations of univariate and multivariate normality, using criteria identified by Tabachnick and Fidell (1996). There were no out-of-range values in the data set, however partial missing data were observed for all scales. In addressing the missing data, the average of the father's and mother's responses were taken in order to address when only one parent's response was available. This step was completed in order to include the highest number of participants' responses, since SPSS analyses will drop a participant's responses to all scales when one item is blank.

Assumptions of Multiple Regression

In addressing normality, parental mental health was bimodal in nature (very low scores and very high scores), but not truncated [see Appendix T]. Parental mental health possessed a mean of 40.16, standard deviation of 12.10. The bimodal nature of this variable will be addressed when specific findings are discussed. The delinquency scores violated the normality assumption as it was a positively skewed distribution platykurtic in nature as well as it possessed a truncated range [see Appendix W]. The mean was 44.45 with a standard deviation of 5.48, and three participants' scores were in the outlier range. This suggests that great caution must be exercised in interpreting this data. Parenting sense of competence was normally distributed [see Appendix U] with a mean of 61.10

and a standard deviation of 7.99. The scores for interpersonal competence were normally distributed [see Appendix V] with a mean of 4.74 and a standard deviation of 0.62.

A Pearson Correlation (1-tailed) was run among the variables of parental mental health, parenting sense of competence, interpersonal competence, and delinquency to test the study's correlational hypotheses. Parental mental health and parenting sense of competence were highly correlated, $r = -.59$, p (one-tailed) $< .000$. There was a significant relationship between parental mental health and children's interpersonal competence, $r = -.33$, p (one-tailed) $< .008$. A low score on parental mental health indicates good parental mental health. There was a significant relationship between parenting sense of competence and children's interpersonal competence, $r = .27$, p (one-tailed) $< .019$. The relationship between parental mental health and children's delinquency was not significant, $r = .18$, p (one-tailed) $< .114$. The relationship between parenting sense of competence and children's delinquency was also not significant, $r = -.02$, p (one-tailed) $<.445$ [see Table 1].

Stepwise Multiple Regression

Stepwise multiple regression were conducted to determine whether predictor variable parental mental health explained more variance in the children's interpersonal competence and delinquent behavior outcome variables than the parent's parenting sense of competence and if parenting sense of competence would explain additional variance beyond that explained by parental mental health. The results indicated that there is a strong relationship between parental mental health and the children's interpersonal competence and that parental mental health explained 10% of the variance in chldren's

interpersonal competence. Although adding parenting sense of competence explains an additional 3% of the variance, the change is not significant [see Table 2]. Regression analysis on the delinquency variable was not conducted because the model was not significant.

Table 1.

Means, Standard Deviations, and Bivariate Correlations of Study Variables

	Variable	M	SD	1	2	3	4
1	Parental Mental Health (PMHpas)	40.16	12.10	--			
2	Parenting Sense of Competence (PSOCpas)	61.10	7.99	-.59**	--		
3	Child's Interpersonal Competence	4.74	.62	-.33**	.27*	--	
4	Child's Delinquency	44.45	5.48	.18	-.02	-.03	--

** = Correlation is significant at the 0.01 level (1-tailed)
* = Correlation is significant at the 0.05 level (1-tailed)

Table 2.

Regression results for interpersonal competence (outcome variable #1).

Model	Variables	Raw B	Std. Beta	T	p
1	$R^2 = .10$; F (1,47) = 5.31; p = .026				
	Total scores (mean) for parents - Parenting Mental Health	-.017	-.319	-2.305	.026
2	$R^2 = .13$; F (2,46) = 3.53; p = .037 $\Delta R^2 = .03$; F change (1,46) = 1.68; p = .20				
	Total scores (mean) for parents - Parenting Mental Health	-.009	-.177	-1.011	.317
	Total scores (mean) for parents - Parenting Sense of Competence	.017	.227	1.294	.202

a. Dependent Variable: Child's Social Competence

Conclusion

This study sought to determine the impact of parenting factors, specifically, parental mental health and parenting sense of competence on the psychosocial adjustment of children who have experienced war. Psychosocial adjustment was evaluated in terms of delinquent behavior and degree of interpersonal competence in the children.

Hammen, Burge, & Stansbury (1990) and Brennan, Hammen, Katz, & Le Brocque (2002) reported that a relationship exists between a mother's and father's mental health and a child's psychosocial functioning. In their study, they found that there is a negative correlation between parental mental health and interpersonal competence. Similarly, in the present study, there was a significant relationship between parental mental health and children's interpersonal competence, supporting the hypothesis that good parental mental health is associated with the children's relational adjustment. That is, low scores on parental mental health (indicating good mental health) were associated with a high score on the children's interpersonal competence (indicating good interpersonal competence). It makes sense that children's ability to engage in relationship with others is likely to be facilitated by the parents' psychological status as evidenced by their mental health. It must be noted, however, that while this correlation was significant, the fact that it did not account for a significant proportion of the variance in the children's interpersonal competence is noteworthy. One possible explanation is that there may be other factors associated with parental mental health such as emotional availability, communication skills, and degree of attachment that explain a greater proportion of the variance in children's interpersonal competence that the present study

did not assess. Another possible explanation for the "muted" findings regarding the impact of parental mental health is the bimodal nature of parental mental health in this study. That is, the results indicated that parents fell into relatively distinct groups, one group having comparatively higher mental health than the other, which suggests that the parents likely represent groups with two levels of adjustment. Therefore, it may be necessary to look at these two groups separately in order to clarify the findings. The two rather different parental levels of adjustment may have resulted from differing levels of war trauma experienced, and/or differences in the length of the exile. Acculturation issues as well as the extent to which they have financial and other resources may also account for parental mental health differences.

The findings as they relate to parenting sense of competence and children's interpersonal competence were found to support the hypothesis of the two variables being positively correlated. It was hypothesized that families whose parents had good parenting sense of competence or, high levels of satisfaction and efficacy regarding the parent's ability to parent, would also have children who would have good interpersonal competence, or, possess a high ability to relate well with parents, teachers, peers, and siblings. The results supported this hypothesis in that those who felt efficacious in fulfilling this role were more likely to raise children who were also more interpersonally confident and competent. It should be noted, however, that parenting sense of competence did not explain a great deal of variance in the children's interpersonal competence. It is likely that, as with parental mental health, communication, attachment, and other parent-child relational dimensions may be more critical factors. In addition, since we were focusing on refugee children, acculturation issues may also play a role in

these children's sense of competence and sense of ability to relate to others in a new country.

The study's findings concerning delinquency indicate that parental mental health and parenting sense of competence did not have significant impact. Sixty-on percent of the children indicated that they had never committed any of the actions listed in the Delinquency Behavior Measure. It is possible that there may have been underreporting by the participants.

In reviewing the strengths and weaknesses of the methodology used, several key items exist. Careful consideration was given to the population of persons who would be interviewed. That is, due to the fluency in Arabic and other Sudanese languages, the consent, assent, instruments, and debriefing forms were translated into Arabic and back translated into English using the translated Arabic version. The translating and back translating process was completed in order to verify validity of the instruments given that the research was of a cross-cultural nature. The potential need for mental health services given the participating families' history of trauma and war was also carefully considered and two referrals to agencies that provide these services were made. Care was also exercised when the Cultural Brokers were chosen and trained for this position. All of the instruments chosen for this study addressed the research question without delving into the specific details of the families' trauma history. This research study was also unique in that it had not been done previously.

Limitations and weaknesses exist concerning the methodology used for this research. An attempt was made to get the Arabic literacy of the Cultural Brokers verified. Although the scales used have been used previously in research, there was

concern about their validity for this population. Indeed, the need to verify each individual administration became apparent when the children's response pattern on the Delinquency Behavior Measure indicated issues of social desirability. This fact was later relayed to the researcher by the Cultural Brokers, but not otherwise known. This also applies to the Hopkins Symptom Checklist-25. It is a scale that has been used with refugee populations; however, the Cultural Brokers also reported that the parents indicated some discomfort with a few of the questions, namely, about sexual matters, and may have underreported.

In order to acquire sensitive information about the children's delinquent acts, a self-report measure was used. It is possible that although the researcher made significant efforts to maintain anonymity and confidentiality, the children may not have felt comfortable disclosing such information in the presence of someone known to them. One Cultural Broker indicated that 75-90% of the children in one group had actually committed delinquent acts, and more than 90% in the other group. This was further verified by the fact that this Cultural Broker served as a translator while accompanying many of the families to their appointments with the Juvenile Court system. In short, the results from the delinquency outcome variable are not valid or salvageable and issues of "social desirability" are likely to have played a role. This may be due to a self-report measure being used. Self-reporting possesses limitations in that the accuracy may be compromised by the individual completing the questionnaire, especially if they believe their results may not be kept totally anonymous. It may, therefore, have been more reliable to acquire information as sensitive as delinquency acts from a secondary source, such as a parent, teacher, or another professional directly connected to the children's

lives. It may have also been more reliable to request that questionnaires be completed in another part of the house and returned to the Cultural Brokers in a sealed and unmarked envelope during the interview, so as to decrease the issues of social desirability.

One instrument was used for each variable in this study, which may also have resulted in limiting the findings. That is, additional sources did not exist to further indicate the accuracy or inaccuracy of the results gathered. The last limitation that this research possessed was the total number of families interviewed. A larger number of participants would have served to substantiate the findings, specifically in light of missing responses.

One Cultural Broker reported that many of the high school students were not reading or writing at grade level. This potentially impacts the comprehension and results of the questionnaires. In the future, it would be beneficial to include a screener assessing the minor's literacy level.

The findings for this research appear to indicate that parental mental health and parenting sense of competence are correlated with a child's psychosocial adjustment. However, other relational and environmental factors exist that may explain a greater proportion of the variance in the children's adjustment. Besides the possibility that this may have been due to underreporting on the part of the parents and children, other explanations exist that range from acculturation contributions to the moderating effects of the level of trauma experienced. In addition, the validity and appropriateness of the measures used would need to be evaluated. Therefore, future research would need to include a method of ensuring that the validity of each individual administration of the instruments be verified. This would be an important issue to address given that it is

cross-cultural research. Cross-cultural research requires that the researcher, data collectors, and the participants are all aware of the meanings and implications of the words and concepts used in the research study so as to decrease underreporting and increase validity. Given that it is cross-cultural research about refugee families, it may be necessary to include a screener on the family's level of acculturation. It may also be necessary to request that the Cultural Brokers have a debriefing session with the respondents concerning their thoughts and feelings about the instruments. This would assist in more accurately interpreting the participants' response patterns, such as the bimodal nature of the parental mental health responses. Furthermore, it may also be more beneficial for the acquisition of accurate data decreasing issues of social desirability to employ Cultural Brokers who are unknown to the children. Therefore, it may serve in ensuring that the children would feel more comfortable reporting delinquent behaviors.

There also exists the need for the families to receive psychological services. It would serve to assist the parents and children in processing the trauma they have experienced due to war. This would also support the study's results concerning good parental mental health being associated with the children's good interpersonal competence.

In the last fifty years of world history, there has been a drastic increase in intergroup conflicts and wars. Furthermore, due to the incorporation of children in the violent actions surrounding these conflicts and wars, it is imperative that psychologist and other social scientists focus their attention on creating and implementing new theories, clinical practices, psychological assessment, and research methodology that will best serve the children and families impacted.

References

Achenbach, T., & Edelbrock, C. (1981). Behavioral problems and competencies reported by parents of normal and disturbed children aged four through sixteen. *Monographs of the Society for Research in Child Development,* 46(1), 1-84.

Adrian, C., & Hammen, C. (1993). Stress exposure and stress generation in children of depressed mothers. *Journal of Consulting and Clinical Psychology*, 61(2), 354-359.

Ajdukovic, M. & Ajdukovic, D. (1998). Impact of displacement on the psychological well-being of refugee children. *International Review of Psychiatry*, 10(3), 186-195.

Anderson, C., Hammen, C. (1993). Psychosocial outcomes of children of unipolar depressed, bipolar, medically ill, and normal women: A longitudinal study. *Journal of Consulting and Clinical Psychology,* 61(3), 448-454.

Appleyard, K., & Osofsky, J. (2003). Parenting after trauma: Supporting parents and caregivers in the treatment of children impacted by violence. *Infant Mental Health Journal*, 24, 111-125.

Baker, A., & Shalhoub-Kevorkian, N. (1999). Effects of political and military traumas on children: The Palestinian case. *Clinical Psychology Review*, 19(8), 935-950.

Bandura, A., Ross, D., & Ross, S. (1961). Transmission of aggression through imitation of aggressive models. *Journal of Abnormal and Social Psychology,* 63(3), 575-582.

Berman, H. (2001). Children and war: Current understandings and future directions. *Public Health Nursing*, 18 (4), 243-252.

Boyden, J. (2003). The moral development of child soldiers: What do adults have to fear? *Peace and Conflict: Journal of Peace Psychology*, 9(4), 343-362.

Brennan, P., Hammen, C., Katz, A., & Le Brocque, R. (2002). Maternal depression, paternal psychopathology, and adolescent diagnostic outcomes. *Journal of Consulting and Clinical Psychology,* 70(5), 1075-1085.

Burge, D., & Hammen, C. (1991). Maternal communication: Predictors of outcome at follow-up in a sample of children at high and low risk for depression. *Journal of Abnormal Psychology,* 100(2), 174-180.

Cairns, R., Leung, M., Gest, S., & Cairns, B. (1995). A brief method for assessing social development: Structure, reliability, stability, and developmental validity of the Interpersonal Competence Scale. *Behavioral Research and Therapy*, 33(6), 725-736.

de Silva, H., Hobbs, C., & Hanks, H. (2001). Conscription of children in armed conflict – A form of child abuse. A study of 19 former child soldiers. Child Abuse Review, 10(2), 125-134.

Derluyn, I., Broekaert, E., Schuyten, G., & De Temmerman, E. (2004). Post-traumatic stress in former Ugandan child soldiers. *Lancet*, 363(9412), 861-863.

Derogatis, L., Lipman, R., Rickels, K., Uhlenhuth, E., & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral Science*, 19(1), 1-15.

Gerull, F., & Rapee, R. (2002). Mother knows best: Effects of maternal modelling on the acquisition of fear and avoidance behaviour in toddlers. *Behaviour Research and Therapy,* 40(3), 279-287.

Hammen, C., Burge, D., & Stansbury, K. (1990). Relationship of mother and child variables to child outcomes in a high-risk sample: A causal modeling analysis. *Developmental Psychology*, 26(1), 24-30.

Jackson, R. (1999). Mommy, there's a nigger at the door. *Journal of Counseling and Development,* 77, 4-6.

Johnston, C. & Mash, E. (1989). A measure of parenting efficacy and competence. *Journal of Clinical Child Psychology,* 18(2), 167-175.

Kendall-Tackett, K., Williams, L., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, 113(1), 164-180.

Kleijn, W., Hovens, J., & Rodenburg, J. (2001). Posttraumatic stress symptoms in Refugees: Assessments with the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist-25 in different languages. *Psychological Reports*, 88(2), 527-532.

Ladd, G., & Cairns, E. (1996). Children: Ethnic and political violence. *Child Development*, 67(1), 14-18.

Lale, T. (1992). Gangs and drugs. In Gary W. Lawson & Ann W. Lawson (Eds.), *Adolescent substance abuse: Etiology, treatment, and prevention* (pp.267-282). Gaithersburg, Maryland: Aspen Publishers.

Mendelsohn, M., & Straker, G. (1998). Child soldiers: Psychosocial implications of the Graça Michel/UN study. Peace and Conflict: Journal of Peace Psychology, 4(4), 399-413.

Mghir, R., & Raskin, A. (1999). The psychological effects of the war in Afghanistan on Young Afghan refugees from different ethnic backgrounds. *International Journal of Social Psychiatry,* 45(2), 29-40.

Mollica, R., Poole, M., Son, L., Murray, C., & Tor, S. (1997). Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. *Journal of American Academy of Adolescent Psychiatry*, 36(8), 1098-1106.

Mollica, R., Wyshak, G., de Marneffe, D., Khoun, F., & Lavelle, J. (1987). Indochinese versions of the Hopkins Symptom Checklist-25: A screening instrument for the psychiatric care of refugees. *American Journal of Psychiatry*, 144(4), 497-500.

Paardekooper, B., de Jong, J., & Hermanns, J. (1999). The psychological impact of war and the refugee situation on south Sudanese children in refugee camps in northern Uganda: An exploratory study. Journal of Child Psychology and Psychiatry, 40 (4), 529-536.

Peacock, M., McClure, F., & Agars, M. (2003). Predictors of delinquent behaviors among Latino youth. *Urban Review*, 35(1), 59-72.

Pearn, J. (2003). Children and war. *Journal of Paediatrics and Child Health*, 39(3), 166-172.

Rousseau C., Drapeau, A., & Platt, R. (1999). Family trauma and its association with emotional and behavioral problems and social adjustment in adolescent Cambodian refugees. *Child Abuse and Neglect*, 23(10), 1263-1273.

Shaw, J. (2003). Children exposed to war/terrorism. *Clinical Child and Family Psychology Review*, 6 (4), 237-246.

Swick, K., & Broadway, F. (1997). Parental efficacy and successful parent involvement. *Journal of Instructional Psychology*, 24(1), 69-75.

Swick, K., & Hassell, T. (1990). Parental efficacy and the development of social competence in young children. *Journal of Instructional Psychology*, 17(1), 24-32.

Tabachnick, B., & Fiddell, L. (1996). *Using multivariate statistics*, 3rd edition. Northridge, CA: HarperCollins College Publishers.

Tobin, J. (2000). Observations on the mental health of a civilian population living under long-term hostilities. *Psychiatric Bulletin*, 24, 69-70.

Walton, J., Nuttall, R., & Nuttall, E. (1997). The impact of war on the mental health of children: A Salvadoran study. *Child Abuse and Neglect*, 21(8), 737-749.

Wolfe, D., & Korsch, B. (1994). Witnessing domestic violence during childhood and adolescence: Implications for pediatric practice. *Pediatrics,* 94(4), 594-599.

Appendix A

Letter of Support

(see the following page)

AfricaCorps

4660 El Cajon Blvd., #212A
San Diego, CA 92115
Phone: (619) 563-0735
Tel/Fax: (619) 563-0941

April 5, 2004

To Whom It May Concern:

SUBJECT: LETTER OF SUPPORT

I, Galwak Deng, give full support for Nola Lawrence to access the clientele of Africa Corps as the subject base for her doctoral dissertation, Psychosocial Adjustment Among Refugee Children. I have reviewed her project and approve of the methods and measurements that will be used to collect data.

For any questions or concerns, please feel free to contact me at the address and number on the letterhead.

Sincerely,

4/6/04

Galwak Deng
Executive Director
AfricaCorps

Appendix B

Orientation Information for Cultural Brokers/Interpreters and Researcher

In order to establish an ethical standard of interviewing, ethical standards, and culturally and psychologically appropriate jargon will be discussed with the Cultural Brokers/Interpreters. To address the culturally and psychologically appropriate terms, continuity between the use and meaning of key psychological jargon and Sudanese cultural viewpoints must exists, a discussion will be held on these topics. It will cover the definition and social stigma of words and practices used to explain emotional suffering and mental health status. This will be further magnified to include the means of treatment generally used. The purpose of the discussion is to verify that the Cultural Brokers/Interpreters and the researcher will have an understanding of each other's viewpoints.

Training will also be given which will include the ethical standards necessary to be maintained for the study's procedures. This will include: participants' rights, participants' confidentiality, the purpose and procedures of the research, the risks, the benefits, reimbursement terms, information for contacting an impartial third party, the reading and discussion of The Belmont Report, and the signing of a form verifying that they have familiarized themselves with the guidelines presented in The Belmont Report (see Appendix M). A form verifying that this training has been received and completed will be signed (see Appendix O).

The Cultural Brokers/Interpreters' duties include:

- Assist the participants in completing all the forms such as, the informed consent, informed assent, personal data sheet, questionnaires, and the debriefing form.

- Clarify and respond to questions asked by the participants.
- Verify that the same procedures in the same order are used with each participant. This will assist in decreasing the number of confounding variables that could be introduced.
- Verify that the terminology used in the Arabic and Nuer languages come as close as possible to the English translation.
- Keep the researcher informed of pertinent information as well as cultural and/or language nuances significant to the research project.

Appendix C

Orientation/Training Packet for Cultural Brokers

(Packet prepared for the orientation and ethics training for Cultural Brokers)

"Psychosocial Adjustment Among Refugee Children"

Orientation and Training Meeting #1

By Nola I. Lawrence, M.A.

Monday, 30 August 2004
6:00p.m.

AfricaCorps
San Diego, CA

Orientation/Training

I. Introduction of Executive Director of AfricaCorps, Cultural Brokers, and Researcher

    A. Background, qualifications, and vision

II. Introduction of the Research and its basis

    A. Vision for mutual benefit of this project

    B. Orientation/Training Requirement

        1. Three meetings

            a) First Meeting

                (1) Orientation about the research project and its procedures

            b) Second Meeting

                (1) Review of a piloted study and discussion of the experience

            c) Third Meeting

                (1) Administer to first family with Researcher present

III. Discussion about the various Sudanese cultures

IV. Discussion about the use and meaning of Sudanese cultural viewpoints and key psychological jargon.

    A. Words and practices used to explain emotional suffering and mental health states

    B. Means of treatment customarily used

V. Research Assistant/Cultural Brokers

    A. Qualifications

VI. Research Assistant/Cultural Brokers

A. Duties

VII. Ethical guidelines and principles training

A. Human Participant Protections Education for Research Team

1. Certification

a) http://cme.cancer.gov/c01

(1) NIH Human Participant Protections Education for Research Teams website (register for course)

b) http://69.5.4.33/c01/toc.php

(1) Training online

VIII. Importance of following Research Procedures accurately

IX. Review of Research Procedures

A. Protocol

B. Matching Numbers

C. Matching Envelopes

D. Making Appointments

E. Compensation for each family

1. $10/family for each completed protocol

F. Procedure for compensating families

X. Training Verification Signed

A. Ethical guidelines and principles training

B. Research Procedures/Protocol Training

XI. Compensation

A. $15 per family who has completed the study

B. Pay Schedule

    1. Once a week

C. Incentive

    1. 100 families completed within 30 working days from first administration of protocol

D. Not required to work on Saturday (Sabbath)

XII. Orientation Training Meetings #2 and #3

A. Orientation/Training Meeting #2

    1. Date:

    2. Time:

    3. Place:

B. Orientation/Training Meeting #3

    1. Date:

    2. Time:

    3. Place:

Abstract

War is a traumatic situation. For children who have gone through the trauma of war, parents may contribute one of the major influences on their psychosocial adjustment. It is predicted that the parents' mental health and their perception of their parenting competence are likely to impact long term adjustment for children who have experienced war trauma. Specifically, it is expected that parents who have good mental health and who feel efficacious in their parenting (i.e., competent), will have children who are more well-adjusted than those who have poor mental health and low sense of parenting competence. The number of delinquent behaviors in which the children engage and how they rate themselves on interpersonal competence -- which includes personal, social, and emotional adjustment, will demonstrate the children's psychosocial adjustment. This study proposes to interview 67 Sudanese families, the father, and/or the mother and one child; for a total of 134 persons. Two questionnaires each will be administered to the parents and the children. The informed consent and assent forms, personal data sheet, and debriefing statement will also be completed. The data will be collected with the help of Cultural Brokers/Interpreters. The data will be analyzed using multiple regression analyses.

Cultural Brokers/Interpreters

Qualifications

- Be a national of, or has been raised in a particular country or cultural group
- Speaks, reads, and writes the language of the person (s) or families who will be interviewed
- Possess knowledge of the jargon and fundamental skills pertaining to the vocation that is seeking to do research, provide services, etc.
- May independently interact with the clients and/or subjects for interviewing or the provision of fundamental services

Duties

- Recruit participants.
- Assist the participants in completing all the forms such as, the informed consent, informed assent, personal data sheet, questionnaires, and the debriefing form.
- Clarify and respond to questions asked by the participants
- Verify that the same procedures in the same order are used with each participant. This will assist in decreasing the number of confounding variables that could be introduced.
- Verify that the terminology used in the Arabic language comes as close as possible to the English translation.
- Keep the researcher informed of pertinent information as well as cultural and/or language nuances significant to the research project.

Cultural Brokers/Interpreters

Qualifications

- Be a national of, or has been raised in a particular country or cultural group
- Speaks, reads, and writes the language of the person (s) or families who will be interviewed
- Possess knowledge of the jargon and fundamental skills pertaining to the vocation that is seeking to do research, provide services, etc.
- May independently interact with the clients and/or subjects for interviewing or the provision of fundamental services

Duties

- Recruit participants.
- Assist the participants in completing all the forms such as, the informed consent, informed assent, personal data sheet, questionnaires, and the debriefing form.
- Clarify and respond to questions asked by the participants
- Verify that the same procedures in the same order are used with each participant. This will assist in decreasing the number of confounding variables that could be introduced.
- Verify that the terminology used in the Arabic language comes as close as possible to the English translation.
- Keep the researcher informed of pertinent information as well as cultural and/or language nuances significant to the research project.

Ethical Guidelines and Principles

(see packet of information)

*see Appendix P

Research Procedures

(see IRB Protocol)

*see Procedure section

Signature of Training Verification

(see attached form)

*see Appendix O

Appendix D

The Belmont Report
Office of the Secretary
Ethical Principles and Guidelines for the Protection of Human Subjects of Research
The National Commission for the Protection of Human Subjects
of Biomedical and Behavioral Research

April 18, 1979

AGENCY: Department of Health, Education, and Welfare.

ACTION: Notice of Report for Public Comment.

SUMMARY: On July 12, 1974, the National Research Act (Pub. L. 93-348) was signed into law, there-by creating the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. One of the charges to the Commission was to identify the basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects and to develop guidelines which should be followed to assure that such research is conducted in accordance with those principles. In carrying out the above, the Commission was directed to consider: **(i)** the boundaries between biomedical and behavioral research and the accepted and routine practice of medicine, **(ii)** the role of assessment of risk-benefit criteria in the determination of the appropriateness of research involving human subjects, **(iii)** appropriate guidelines for the selection of human subjects for participation in such research and **(iv)** the nature and definition of informed consent in various research settings.

The Belmont Report attempts to summarize the basic ethical principles identified by the Commission in the course of its deliberations. It is the outgrowth of an intensive four-day period of discussions that were held in February 1976 at the Smithsonian Institution's Belmont Conference Center supplemented by the monthly deliberations of the Commission that were held over a period of nearly four years. It is a statement of basic ethical principles and guidelines that should assist in resolving the ethical problems that surround the conduct of research with human subjects. By publishing the Report in the Federal Register, and providing reprints upon request, the Secretary intends that it may be made readily available to scientists, members of Institutional Review Boards, and Federal employees. The two-volume Appendix, containing the lengthy reports of experts and specialists who assisted the Commission in fulfilling this part of its charge, is available as DHEW Publication No. (OS) 78-0013 and No. (OS) 78-0014, for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Unlike most other reports of the Commission, the Belmont Report does not make specific recommendations for administrative action by the Secretary of Health, Education, and

Welfare. Rather, the Commission recommended that the Belmont Report be adopted in its entirety, as a statement of the Department's policy. The Department requests public comment on this recommendation.

National Commission for the Protection of Human Subjects

of Biomedical and Behavioral Research

Members of the Commission

Kenneth John Ryan, M.D., Chairman, Chief of Staff, Boston Hospital for Women.
Joseph V. Brady, Ph.D., Professor of Behavioral Biology, Johns Hopkins University.
Robert E. Cooke, M.D., President, Medical College of Pennsylvania.
Dorothy I. Height, President, National Council of Negro Women, Inc.
Albert R. Jonsen, Ph.D., Associate Professor of Bioethics, University of California at San Francisco.
Patricia King, J.D., Associate Professor of Law, Georgetown University Law Center.
Karen Lebacqz, Ph.D., Associate Professor of Christian Ethics, Pacific School of Religion.
**** David W. Louisell, J.D., Professor of Law, University of California at Berkeley.*
Donald W. Seldin, M.D., Professor and Chairman, Department of Internal Medicine, University of Texas at Dallas.
****Eliot Stellar, Ph.D., Provost of the University and Professor of Physiological Psychology, University of Pennsylvania.*
**** Robert H. Turtle, LL.B., Attorney, VomBaur, Coburn, Simmons & Turtle, Washington, D.C.*

**** Deceased.*

Table of Contents

Ethical Principles & Guidelines for Research Involving Human Subjects

Scientific research has produced substantial social benefits. It has also posed some troubling ethical questions. Public attention was drawn to these questions by reported abuses of human subjects in biomedical experiments, especially during the Second World War. During the Nuremberg War Crime Trials, the Nuremberg code was drafted as a set of standards for judging physicians and scientists who had conducted biomedical experiments on concentration camp prisoners. This code became the prototype of many later codes(1) intended to assure that research involving human subjects would be carried out in an ethical manner.

The codes consist of rules, some general, others specific, that guide the investigators or the reviewers of research in their work. Such rules often are inadequate to cover complex situations; at times they come into conflict, and they are frequently difficult to interpret or apply. Broader ethical principles will provide a basis on which specific rules may be formulated, criticized and interpreted.

Three principles, or general prescriptive judgments, that are relevant to research involving human subjects are identified in this statement. Other principles may also be relevant. These three are comprehensive, however, and are stated at a level of generalization that should assist scientists, subjects, reviewers and interested citizens to understand the ethical issues inherent in research involving human subjects. These principles cannot always be applied so as to resolve beyond dispute particular ethical problems. The objective is to provide an analytical framework that will guide the resolution of ethical problems arising from research involving human subjects.

This statement consists of a distinction between research and practice, a discussion of the three basic ethical principles, and remarks about the application of these principles.

Part A: Boundaries Between Practice & Research

A. Boundaries Between Practice and Research

It is important to distinguish between biomedical and behavioral research, on the one hand, and the practice of accepted therapy on the other, in order to know what activities ought to undergo review for the protection of human subjects of research. The distinction between research and practice is blurred partly because both often occur together (as in research designed to evaluate a therapy) and partly because notable departures from standard practice are often called "experimental" when the terms "experimental" and "research" are not carefully defined.

For the most part, the term "practice" refers to interventions that are designed solely to enhance the well-being of an individual patient or client and that have a reasonable expectation of success. The purpose of medical or behavioral practice is to provide diagnosis, preventive treatment or therapy to particular individuals.(2) By contrast, the

term "research' designates an activity designed to test an hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge (expressed, for example, in theories, principles, and statements of relationships). Research is usually described in a formal protocol that sets forth an objective and a set of procedures designed to reach that objective.

When a clinician departs in a significant way from standard or accepted practice, the innovation does not, in and of itself, constitute research. The fact that a procedure is "experimental," in the sense of new, untested or different, does not automatically place it in the category of research. Radically new procedures of this description should, however, be made the object of formal research at an early stage in order to determine whether they are safe and effective. Thus, it is the responsibility of medical practice committees, for example, to insist that a major innovation be incorporated into a formal research project.(3)

Research and practice may be carried on together when research is designed to evaluate the safety and efficacy of a therapy. This need not cause any confusion regarding whether or not the activity requires review; the general rule is that if there is any element of research in an activity, that activity should undergo review for the protection of human subjects.

Part B: Basic Ethical Principles

B. Basic Ethical Principles

The expression "basic ethical principles" refers to those general judgments that serve as a basic justification for the many particular ethical prescriptions and evaluations of human actions. Three basic principles, among those generally accepted in our cultural tradition, are particularly relevant to the ethics of research involving human subjects: the principles of respect of persons, beneficence and justice.

1. Respect for Persons. -- Respect for persons incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy.

An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to autonomous persons' considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others. To show lack of respect for an autonomous agent is to repudiate that person's considered judgments, to deny an individual the freedom to act on those considered judgments, or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so.

However, not every human being is capable of self-determination. The capacity for self-determination matures during an individual's life, and some individuals lose this capacity wholly or in part because of illness, mental disability, or circumstances that severely restrict liberty. Respect for the immature and the incapacitated may require protecting them as they mature or while they are incapacitated.

Some persons are in need of extensive protection, even to the point of excluding them from activities which may harm them; other persons require little protection beyond making sure they undertake activities freely and with awareness of possible adverse consequence. The extent of protection afforded should depend upon the risk of harm and the likelihood of benefit. The judgment that any individual lacks autonomy should be periodically reevaluated and will vary in different situations.

In most cases of research involving human subjects, respect for persons demands that subjects enter into the research voluntarily and with adequate information. In some situations, however, application of the principle is not obvious. The involvement of prisoners as subjects of research provides an instructive example. On the one hand, it would seem that the principle of respect for persons requires that prisoners not be deprived of the opportunity to volunteer for research. On the other hand, under prison conditions they may be subtly coerced or unduly influenced to engage in research activities for which they would not otherwise volunteer. Respect for persons would then dictate that prisoners be protected. Whether to allow prisoners to "volunteer" or to "protect" them presents a dilemma. Respecting persons, in most hard cases, is often a matter of balancing competing claims urged by the principle of respect itself.

2. Beneficence. -- Persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being. Such treatment falls under the principle of beneficence. The term "beneficence" is often understood to cover acts of kindness or charity that go beyond strict obligation. In this document, beneficence is understood in a stronger sense, as an obligation. Two general rules have been formulated as complementary expressions of beneficent actions in this sense: **(1)** do not harm and **(2)** maximize possible benefits and minimize possible harms.

The Hippocratic maxim "do no harm" has long been a fundamental principle of medical ethics. Claude Bernard extended it to the realm of research, saying that one should not injure one person regardless of the benefits that might come to others. However, even avoiding harm requires learning what is harmful; and, in the process of obtaining this information, persons may be exposed to risk of harm. Further, the Hippocratic Oath requires physicians to benefit their patients "according to their best judgment." Learning what will in fact benefit may require exposing persons to risk. The problem posed by these imperatives is to decide when it is justifiable to seek certain benefits despite the risks involved, and when the benefits should be foregone because of the risks.

The obligations of beneficence affect both individual investigators and society at large, because they extend both to particular research projects and to the entire enterprise of

research. In the case of particular projects, investigators and members of their institutions are obliged to give forethought to the maximization of benefits and the reduction of risk that might occur from the research investigation. In the case of scientific research in general, members of the larger society are obliged to recognize the longer term benefits and risks that may result from the improvement of knowledge and from the development of novel medical, psychotherapeutic, and social procedures.

The principle of beneficence often occupies a well-defined justifying role in many areas of research involving human subjects. An example is found in research involving children. Effective ways of treating childhood diseases and fostering healthy development are benefits that serve to justify research involving children -- even when individual research subjects are not direct beneficiaries. Research also makes it possible to avoid the harm that may result from the application of previously accepted routine practices that on closer investigation turn out to be dangerous. But the role of the principle of beneficence is not always so unambiguous. A difficult ethical problem remains, for example, about research that presents more than minimal risk without immediate prospect of direct benefit to the children involved. Some have argued that such research is inadmissible, while others have pointed out that this limit would rule out much research promising great benefit to children in the future. Here again, as with all hard cases, the different claims covered by the principle of beneficence may come into conflict and force difficult choices.

3. Justice. -- Who ought to receive the benefits of research and bear its burdens? This is a question of justice, in the sense of "fairness in distribution" or "what is deserved." An injustice occurs when some benefit to which a person is entitled is denied without good reason or when some burden is imposed unduly. Another way of conceiving the principle of justice is that equals ought to be treated equally. However, this statement requires explication. Who is equal and who is unequal? What considerations justify departure from equal distribution? Almost all commentators allow that distinctions based on experience, age, deprivation, competence, merit and position do sometimes constitute criteria justifying differential treatment for certain purposes. It is necessary, then, to explain in what respects people should be treated equally. There are several widely accepted formulations of just ways to distribute burdens and benefits. Each formulation mentions some relevant property on the basis of which burdens and benefits should be distributed. These formulations are **(1)** to each person an equal share, **(2)** to each person according to individual need, **(3)** to each person according to individual effort, **(4)** to each person according to societal contribution, and **(5)** to each person according to merit.

Questions of justice have long been associated with social practices such as punishment, taxation and political representation. Until recently these questions have not generally been associated with scientific research. However, they are foreshadowed even in the earliest reflections on the ethics of research involving human subjects. For example, during the 19th and early 20th centuries the burdens of serving as research subjects fell largely upon poor ward patients, while the benefits of improved medical care flowed primarily to private patients. Subsequently, the exploitation of unwilling prisoners as research subjects in Nazi concentration camps was condemned as a particularly flagrant

injustice. In this country, in the 1940's, the Tuskegee syphilis study used disadvantaged, rural black men to study the untreated course of a disease that is by no means confined to that population. These subjects were deprived of demonstrably effective treatment in order not to interrupt the project, long after such treatment became generally available. Against this historical background, it can be seen how conceptions of justice are relevant to research involving human subjects. For example, the selection of research subjects needs to be scrutinized in order to determine whether some classes (e.g., welfare patients, particular racial and ethnic minorities, or persons confined to institutions) are being systematically selected simply because of their easy availability, their compromised position, or their manipulability, rather than for reasons directly related to the problem being studied. Finally, whenever research supported by public funds leads to the development of therapeutic devices and procedures, justice demands both that these not provide advantages only to those who can afford them and that such research should not unduly involve persons from groups unlikely to be among the beneficiaries of subsequent applications of the research.

Part C: Applications

C. Applications

Applications of the general principles to the conduct of research leads to consideration of the following requirements: informed consent, risk/benefit assessment, and the selection of subjects of research.

1. Informed Consent. -- Respect for persons requires that subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them. This opportunity is provided when adequate standards for informed consent are satisfied.

While the importance of informed consent is unquestioned, controversy prevails over the nature and possibility of an informed consent. Nonetheless, there is widespread agreement that the consent process can be analyzed as containing three elements: information, comprehension and voluntariness.

Information. Most codes of research establish specific items for disclosure intended to assure that subjects are given sufficient information. These items generally include: the research procedure, their purposes, risks and anticipated benefits, alternative procedures (where therapy is involved), and a statement offering the subject the opportunity to ask questions and to withdraw at any time from the research. Additional items have been proposed, including how subjects are selected, the person responsible for the research, etc.

However, a simple listing of items does not answer the question of what the standard should be for judging how much and what sort of information should be provided. One standard frequently invoked in medical practice, namely the information commonly provided by practitioners in the field or in the locale, is inadequate since research takes place precisely when a common understanding does not exist.

Another standard, currently popular in malpractice law, requires the practitioner to reveal the information that reasonable persons would wish to know in order to make a decision regarding their care. This, too, seems insufficient since the research subject, being in essence a volunteer, may wish to know considerably more about risks gratuitously undertaken than do patients who deliver themselves into the hand of a clinician for needed care. It may be that a standard of "the reasonable volunteer" should be proposed: the extent and nature of information should be such that persons, knowing that the procedure is neither necessary for their care nor perhaps fully understood, can decide whether they wish to participate in the furthering of knowledge. Even when some direct benefit to them is anticipated, the subjects should understand clearly the range of risk and the voluntary nature of participation.

A special problem of consent arises where informing subjects of some pertinent aspect of the research is likely to impair the validity of the research. In many cases, it is sufficient to indicate to subjects that they are being invited to participate in research of which some features will not be revealed until the research is concluded. In all cases of research involving incomplete disclosure, such research is justified only if it is clear that **(1)** incomplete disclosure is truly necessary to accomplish the goals of the research, **(2)** there are no undisclosed risks to subjects that are more than minimal, and **(3)** there is an adequate plan for debriefing subjects, when appropriate, and for dissemination of research results to them. Information about risks should never be withheld for the purpose of eliciting the cooperation of subjects, and truthful answers should always be given to direct questions about the research. Care should be taken to distinguish cases in which disclosure would destroy or invalidate the research from cases in which disclosure would simply inconvenience the investigator.

Comprehension. The manner and context in which information is conveyed is as important as the information itself. For example, presenting information in a disorganized and rapid fashion, allowing too little time for consideration or curtailing opportunities for questioning, all may adversely affect a subject's ability to make an informed choice. Because the subject's ability to understand is a function of intelligence, rationality, maturity and language, it is necessary to adapt the presentation of the information to the subject's capacities. Investigators are responsible for ascertaining that the subject has comprehended the information. While there is always an obligation to ascertain that the information about risk to subjects is complete and adequately comprehended, when the risks are more serious, that obligation increases. On occasion, it may be suitable to give some oral or written tests of comprehension.

Special provision may need to be made when comprehension is severely limited -- for example, by conditions of immaturity or mental disability. Each class of subjects that one might consider as incompetent (e.g., infants and young children, mentally disable patients, the terminally ill and the comatose) should be considered on its own terms. Even for these persons, however, respect requires giving them the opportunity to choose to the extent they are able, whether or not to participate in research. The objections of these subjects to involvement should be honored, unless the research entails providing them a therapy unavailable elsewhere. Respect for persons also requires seeking the permission

of other parties in order to protect the subjects from harm. Such persons are thus respected both by acknowledging their own wishes and by the use of third parties to protect them from harm.

The third parties chosen should be those who are most likely to understand the incompetent subject's situation and to act in that person's best interest. The person authorized to act on behalf of the subject should be given an opportunity to observe the research as it proceeds in order to be able to withdraw the subject from the research, if such action appears in the subject's best interest.

Voluntariness. An agreement to participate in research constitutes a valid consent only if voluntarily given. This element of informed consent requires conditions free of coercion and undue influence. Coercion occurs when an overt threat of harm is intentionally presented by one person to another in order to obtain compliance. Undue influence, by contrast, occurs through an offer of an excessive, unwarranted, inappropriate or improper reward or other overture in order to obtain compliance. Also, inducements that would ordinarily be acceptable may become undue influences if the subject is especially vulnerable.

Unjustifiable pressures usually occur when persons in positions of authority or commanding influence -- especially where possible sanctions are involved -- urge a course of action for a subject. A continuum of such influencing factors exists, however, and it is impossible to state precisely where justifiable persuasion ends and undue influence begins. But undue influence would include actions such as manipulating a person's choice through the controlling influence of a close relative and threatening to withdraw health services to which an individual would otherwise be entitle.

2. Assessment of Risks and Benefits. -- The assessment of risks and benefits requires a careful arrayal of relevant data, including, in some cases, alternative ways of obtaining the benefits sought in the research. Thus, the assessment presents both an opportunity and a responsibility to gather systematic and comprehensive information about proposed research. For the investigator, it is a means to examine whether the proposed research is properly designed. For a review committee, it is a method for determining whether the risks that will be presented to subjects are justified. For prospective subjects, the assessment will assist the determination whether or not to participate.

The Nature and Scope of Risks and Benefits. The requirement that research be justified on the basis of a favorable risk/benefit assessment bears a close relation to the principle of beneficence, just as the moral requirement that informed consent be obtained is derived primarily from the principle of respect for persons. The term "risk" refers to a possibility that harm may occur. However, when expressions such as "small risk" or "high risk" are used, they usually refer (often ambiguously) both to the chance (probability) of experiencing a harm and the severity (magnitude) of the envisioned harm.

The term "benefit" is used in the research context to refer to something of positive value related to health or welfare. Unlike, "risk," "benefit" is not a term that expresses

probabilities. Risk is properly contrasted to probability of benefits, and benefits are properly contrasted with harms rather than risks of harm. Accordingly, so-called risk/benefit assessments are concerned with the probabilities and magnitudes of possible harm and anticipated benefits. Many kinds of possible harms and benefits need to be taken into account. There are, for example, risks of psychological harm, physical harm, legal harm, social harm and economic harm and the corresponding benefits. While the most likely types of harms to research subjects are those of psychological or physical pain or injury, other possible kinds should not be overlooked.

Risks and benefits of research may affect the individual subjects, the families of the individual subjects, and society at large (or special groups of subjects in society). Previous codes and Federal regulations have required that risks to subjects be outweighed by the sum of both the anticipated benefit to the subject, if any, and the anticipated benefit to society in the form of knowledge to be gained from the research. In balancing these different elements, the risks and benefits affecting the immediate research subject will normally carry special weight. On the other hand, interests other than those of the subject may on some occasions be sufficient by themselves to justify the risks involved in the research, so long as the subjects' rights have been protected. Beneficence thus requires that we protect against risk of harm to subjects and also that we be concerned about the loss of the substantial benefits that might be gained from research.

The Systematic Assessment of Risks and Benefits. It is commonly said that benefits and risks must be "balanced" and shown to be "in a favorable ratio." The metaphorical character of these terms draws attention to the difficulty of making precise judgments. Only on rare occasions will quantitative techniques be available for the scrutiny of research protocols. However, the idea of systematic, nonarbitrary analysis of risks and benefits should be emulated insofar as possible. This ideal requires those making decisions about the justifiability of research to be thorough in the accumulation and assessment of information about all aspects of the research, and to consider alternatives systematically. This procedure renders the assessment of research more rigorous and precise, while making communication between review board members and investigators less subject to misinterpretation, misinformation and conflicting judgments. Thus, there should first be a determination of the validity of the presuppositions of the research; then the nature, probability and magnitude of risk should be distinguished with as much clarity as possible. The method of ascertaining risks should be explicit, especially where there is no alternative to the use of such vague categories as small or slight risk. It should also be determined whether an investigator's estimates of the probability of harm or benefits are reasonable, as judged by known facts or other available studies.

Finally, assessment of the justifiability of research should reflect at least the following considerations: **(i)** Brutal or inhumane treatment of human subjects is never morally justified. **(ii)** Risks should be reduced to those necessary to achieve the research objective. It should be determined whether it is in fact necessary to use human subjects at all. Risk can perhaps never be entirely eliminated, but it can often be reduced by careful attention to alternative procedures. **(iii)** When research involves significant risk of serious impairment, review committees should be extraordinarily insistent on the justification of

the risk (looking usually to the likelihood of benefit to the subject -- or, in some rare cases, to the manifest voluntariness of the participation). **(iv)** When vulnerable populations are involved in research, the appropriateness of involving them should itself be demonstrated. A number of variables go into such judgments, including the nature and degree of risk, the condition of the particular population involved, and the nature and level of the anticipated benefits. **(v)** Relevant risks and benefits must be thoroughly arrayed in documents and procedures used in the informed consent process.

3. Selection of Subjects. -- Just as the principle of respect for persons finds expression in the requirements for consent, and the principle of beneficence in risk/benefit assessment, the principle of justice gives rise to moral requirements that there be fair procedures and outcomes in the selection of research subjects.
Justice is relevant to the selection of subjects of research at two levels: the social and the individual. Individual justice in the selection of subjects would require that researchers exhibit fairness: thus, they should not offer potentially beneficial research only to some patients who are in their favor or select only "undesirable" persons for risky research. Social justice requires that distinction be drawn between classes of subjects that ought, and ought not, to participate in any particular kind of research, based on the ability of members of that class to bear burdens and on the appropriateness of placing further burdens on already burdened persons. Thus, it can be considered a matter of social justice that there is an order of preference in the selection of classes of subjects (e.g., adults before children) and that some classes of potential subjects (e.g., the institutionalized mentally infirm or prisoners) may be involved as research subjects, if at all, only on certain conditions.

Injustice may appear in the selection of subjects, even if individual subjects are selected fairly by investigators and treated fairly in the course of research. Thus injustice arises from social, racial, sexual and cultural biases institutionalized in society. Thus, even if individual researchers are treating their research subjects fairly, and even if IRBs are taking care to assure that subjects are selected fairly within a particular institution, unjust social patterns may nevertheless appear in the overall distribution of the burdens and benefits of research. Although individual institutions or investigators may not be able to resolve a problem that is pervasive in their social setting, they can consider distributive justice in selecting research subjects.

Some populations, especially institutionalized ones, are already burdened in many ways by their infirmities and environments. When research is proposed that involves risks and does not include a therapeutic component, other less burdened classes of persons should be called upon first to accept these risks of research, except where the research is directly related to the specific conditions of the class involved. Also, even though public funds for research may often flow in the same directions as public funds for health care, it seems unfair that populations dependent on public health care constitute a pool of preferred research subjects if more advantaged populations are likely to be the recipients of the benefits.

One special instance of injustice results from the involvement of vulnerable subjects. Certain groups, such as racial minorities, the economically disadvantaged, the very sick, and the institutionalized may continually be sought as research subjects, owing to their ready availability in settings where research is conducted. Given their dependent status and their frequently compromised capacity for free consent, they should be protected against the danger of being involved in research solely for administrative convenience, or because they are easy to manipulate as a result of their illness or socioeconomic condition.

---

(1) Since 1945, various codes for the proper and responsible conduct of human experimentation in medical research have been adopted by different organizations. The best known of these codes are the Nuremberg Code of 1947, the Helsinki Declaration of 1964 (revised in 1975), and the 1971 Guidelines (codified into Federal Regulations in 1974) issued by the U.S. Department of Health, Education, and Welfare Codes for the conduct of social and behavioral research have also been adopted, the best known being that of the American Psychological Association, published in 1973.

(2) Although practice usually involves interventions designed solely to enhance the well-being of a particular individual, interventions are sometimes applied to one individual for the enhancement of the well-being of another (e.g., blood donation, skin grafts, organ transplants) or an intervention may have the dual purpose of enhancing the well-being of a particular individual, and, at the same time, providing some benefit to others (e.g., vaccination, which protects both the person who is vaccinated and society generally). The fact that some forms of practice have elements other than immediate benefit to the individual receiving an intervention, however, should not confuse the general distinction between research and practice. Even when a procedure applied in practice may benefit some other person, it remains an intervention designed to enhance the well-being of a particular individual or groups of individuals; thus, it is practice and need not be reviewed as research.

(3) Because the problems related to social experimentation may differ substantially from those of biomedical and behavioral research, the Commission specifically declines to make any policy determination regarding such research at this time. Rather, the Commission believes that the problem ought to be addressed by one of its successor bodies.

National Institutes of Health
Bethesda, Maryland 20892

Appendix E

Cultural Brokers' Verification of Training

Title: Psychosocial Adjustment Among Refugee Children

Statement: I have read and familiarized myself with the ethical principles and guidelines for research involving human subjects, including The Belmont Report. This includes, respect for persons, beneficence, justice, informed consent, assessment of risk and benefits, and selection of subjects. I have also completed the required orientation. I will apply these ethical principles and guidelines as I collect data for the Psychosocial Adjustment Among Refugee Children research study.

Printed Name of Cultural Broker	Date
Signature of Cultural Broker	Date
Printed Name of Investigator	Date
Signature of Investigator	Date

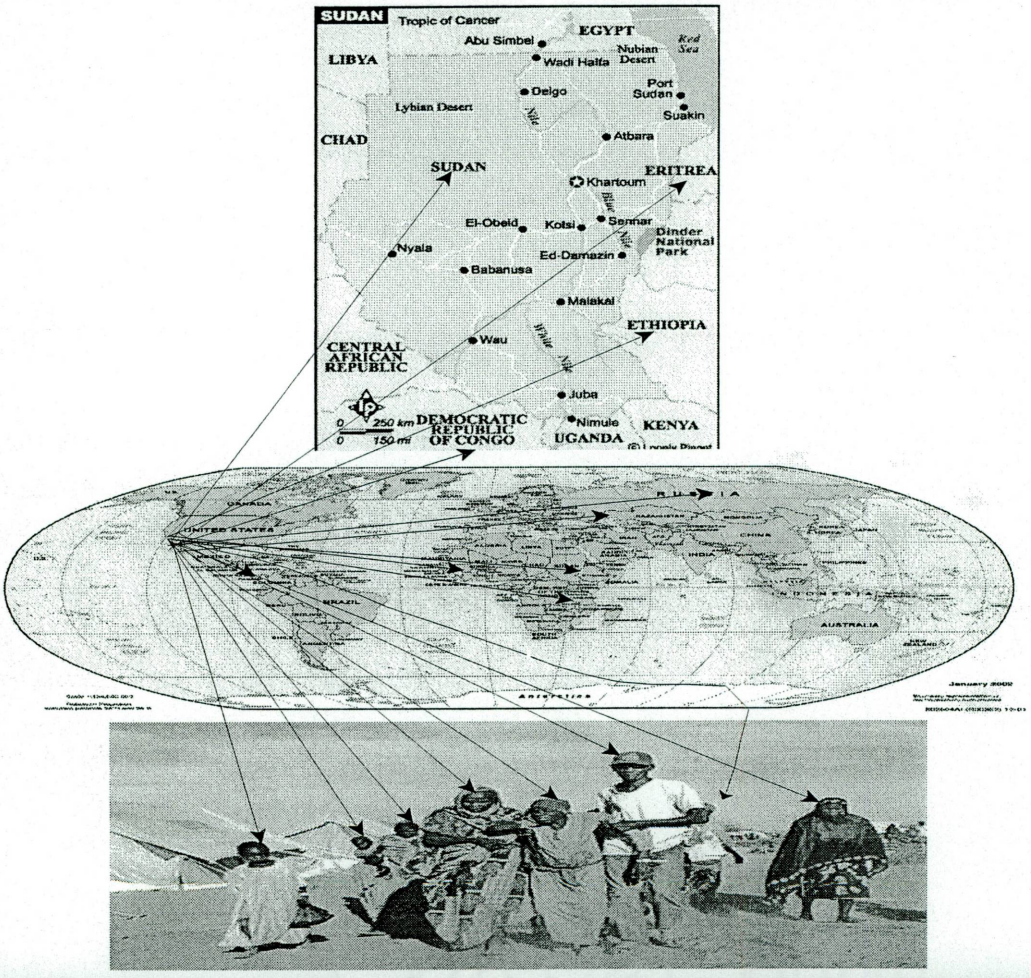
Appendix F

Flyer Announcing Study

(see following page)

Refugee Study

Title: Psychosocial Adjustment Among Refugee Children



You and Your Child Can Help...

other parents and children who have gone through war by talking about how you handle day-to-day situations.

Participants wanted for this study.
The study will take only 1 hour to be completed at your convenience in your home.

Every family who completes the study will be awarded $10.

For More Information Contact:

Mr. Galwak Deng
AfricaCorps
(619) 563-0735

Student's Doctoral Dissertation: **Nola Lawrence, M.A.**

Sponsored by:

Department of Psychology
Loma Linda University
Loma Linda, CA 92350

Appendix G

Scripts for Verbal Announcements

The congregation/audience will be introduced to the researcher and Cultural Brokers by Mr. Galwak Deng (Executive Director of AfricaCorps) and/or other community leaders. Then, a brief summary of the study will be given. The podium will be given to the researcher and Cultural Brokers. The following will be the script that will be used:

"On June 15, 2004, the United Nations High Commissioner for Refugees (UNHCR) submitted a report of the 2003 Global Refugee Trends. By the end of last year, 9,671,831 persons became refugees, half of whom were below the age of 18. Of the 9,671,831 refugee persons, 606,200 were from Sudan, and approximately, 339,472 were under the age of 18. What does this mean? People numbering the populations of some countries need assistance adjusting to life after a war. Families, parents, and children **need** help adjusting to life after a war! The question becomes, how can parents help their children adjust to life after a war? *The help parents give their children today is the help the children can give society tomorrow.* I am here to learn how you have been helping your children adjust by asking how you handle day-to-day situations. I hope that the answers you give will eventually help teachers, counselors, agencies, funding organizations, researchers, policy makers, and other professionals help parents to assist their children in the adjustment process. I am looking for each family's father, mother, and a child between the ages of 11-18 to participate. The study will take about one hour to be completed at your convenience in your home. For every family who completes the study, they will be awarded $10. Please fill out this card so we can contact you. If there

are people who you think would like to participate, please take this card to them and have them contact us. *Remember, this will help other parents and children to adjust to life after war*."

Appendix H

Interest Card

Research study
Title: *Psychosocial Adjustment Among Refugee Children*
You and Your Child Can Help . . . other parents and children who have gone through war by talking about how you handle day-to-day situations.
The study will take **1 hour** to be completed **in your home** at **your convenience**. Every family who completes the study will be awarded $10.
Name: _____ Phone: ( ) _____ Best Time To Call: _____
For More Information contact: Mr. Galwak Deng (619) 563-0735
Student's Doctoral Dissertation: Nola Lawrence, M.A. Sponsored by: Department of Psychology Loma Linda University Loma Linda, CA

Appendix I

Informed Consent Form

(Parents & Minors 13-18)

Psychosocial Adjustment Among Refugee Children

Purpose and Procedures:

You are invited to participate in a research study because you and your child are refugees. The purpose of this study is to learn how parents help their children adjust to past war-related experiences. Participation in this study takes approximately 60 minutes for both parents and children to answer questions about your experience. The questionnaires will ask you, the parents, how you have felt in the last seven days and how you handle day-to-day parenting situations. You, the children, will be asked how often you have done certain things as well as questions about your social life.

Risks:

If you and your child agree to be in the study, you may be uncomfortable or even feel distress at the memories. We will give you some information about agencies you may contact for help, if you wish.

Benefits:

This study may benefit the teachers, counselors, researchers, policy makers, and other professionals who work with refugee persons so that they may have a greater understanding of how to provide services. There may be no personal benefit to you.

Participants' Rights:

You do not have to take part in this study. It is your choice.

Confidentiality:

Your name will not be used in any written report.

Reimbursement:

Each family who finishes the study will be given a $10 prize.

Impartial Third Party Contact:

If you wish to contact an impartial third party not associated with this study regarding any complaint you may have, contact: Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, phone (909) 558-4647.

Informed Consent Statement:
I have read the contents of the consent form and have listened to the verbal explanation given by the investigator. My questions concerning this study have been answered to my satisfaction. I hereby give voluntary consent to participate in this study and for my child to participate in this study, as well. Signing this consent document and does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities. I may call Nola Lawrence, M.A., Student Researcher, phone (909) 558-8577 or Faith McClure, Ph.D., Research Advisor, phone (909) 880-5598 (investigators) during routine office hours, if I have additional questions or concerns. This study has been explained to my child at a level he/she can understand and I give my consent for my child to participate in this study. I have been given a copy of this consent form.

Signatures:

_____ _____
Signature of subject Date

_____ _____
Signature of witness Date

_____ _____
Signature of parent Date

_____ _____
Cultural Brokers Date
*explained/answered questions in subjects' language

Investigator's statement:
The Cultural Brokers have reviewed the contents of the California Experimental Subject's Bill of Rights and this consent form with the person signing above. They have explained potential risks and benefits of the study.

_____ _____
Investigator or Cultural Brokers Phone Number Date

Appendix J

Assent Form for Minors (ages 11-12)

Psychosocial Adjustment Among Refugee Children

Introduction:

Would you help us learn about parents and children who have gone through war? Nola Lawrence is studying children and how parents help them deal with war.

Description of the study:

For this study, you and your parents will take about 45 minutes to fill out the personal data sheet and two questionnaires each. The questionnaires will ask you how often you have done certain things as well as questions about your social life. Your parents will be asked how they have felt in the last seven days as well as how they handle different things that happen from day to day.

Possible problems:

You may remember some of the memories that were very scary. If this happens, you and your parents will be given the names of counselors who can help you feel better.

Possible good that may result from the study:

We hope to show the things parents do to help their children get used to life after the war, so that we may be able to help other parents and children who have lived through a war.

I have had this study explained to me, and have been able to ask questions about the study. I give permission for this study to be done on me.

_____ _____

Signature of Subject, ages 11-12 years Date

_____ _____

Witness Date

Appendix K

Personal Data Sheet (Parents & Minors)

1) Age: _____

2) Gender: ❑ male ❑ female

3) Country of origin/birth of Parent: _____

4) Ethnic/Cultural group: _____

5) Languages spoken: _____

6) Languages written: _____

7) Religious affiliation: _____

8) Total number of years spent outside of country of origin/birth:

❑ Less than 5 ❑ 5-10 ❑ 10-15 ❑ 15-20 ❑ 20-25 ❑ 25+

9) List the names of the countries lived after leaving birth country and the amount of time spent there:

Countries	Amount of time
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

10) From your point of view, how traumatic was the displacement?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
Least Most

11) How long ago did you live in a country that was going through war? _____

12) At school, children receive:

❑ Free lunch ❑ Reduced lunch ❑ No assistance

13) Total number of persons living in your household:

Adults:_____ Children:_____

14) Father's occupation _____

15) Mother's occupation _____

16) Father's highest level of education _____

17) Mother's highest level of education _____

18) Child/Adolescent's grade in school _____

19) I am living with:

❑ Father and mother ❑ father only ❑ mother only ❑ relatives

❑ Other (specify): _____

Appendix L

Hopkins Symptom Checklist-25 (Parents)

Instructions: Listed below are some symptoms or problems that people sometimes have. Please read each one carefully and decide how much the symptoms bothered or distressed you in the last week, including today. Circle the appropriate column.

		Not at all	A little	Quite a bit	Extremely
1	Feeling blue	1	2	3	4
2	Loss of sexual interest or pleasure	1	2	3	4
3	Headaches	1	2	3	4
4	Worrying too much about things	1	2	3	4
5	Feeling trapped or caught	1	2	3	4
6	Difficulty falling asleep or staying asleep	1	2	3	4
7	Feeling low in energy, slowed down	1	2	3	4
8	Blaming oneself for things	1	2	3	4
9	Poor appetite	1	2	3	4
10	Heart pounding or racing	1	2	3	4
11	Feeling everything is an effort	1	2	3	4
12	Feeling hopeless about the future	1	2	3	4
13	Feeling fearful	1	2	3	4
14	Crying easily	1	2	3	4
15	Spells of terror or panic	1	2	3	4
16	Feeling no interest in things	1	2	3	4
17	Faintness, dizziness, or weakness	1	2	3	4
18	Feeling lonely	1	2	3	4
19	Being suddenly scared for no reason	1	2	3	4
20	Feelings of worthlessness	1	2	3	4
21	Feeling restless, not being able to sit still	1	2	3	4
22	Thoughts of ending one's life	1	2	3	4
23	Nervousness or shakiness inside	1	2	3	4
24	Feeling tense or keyed up	1	2	3	4
25	Trembling	1	2	3	4

Appendix M

Parenting Sense of Competence Scale (PSOC) (Parents)

Being A Parent

Date _____

Listed below are a number of statements. Please respond to each item, indicating your agreement or disagreement with each statement in the following manner.

If you strongly agree, circle the letters SA.
If you agree, circle the letter A.
If you mildly agree, circle the letters MA.
If you mildly disagree, circle the letter MD.
If you disagree, circle the letter D.
If you strongly disagree, circle the letters SD.

1. The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired. SA A MA MD D SD

2. Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age. SA A MA MD D SD

3. I go to bed the same way I wake up in the morning – feeling I have not accomplished a whole lot. SA A MA MD D SD

4. I do not know what it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated. SA A MA MD D SD

5. My mother was better prepared to be a good mother than I am. SA A MA MD D SD

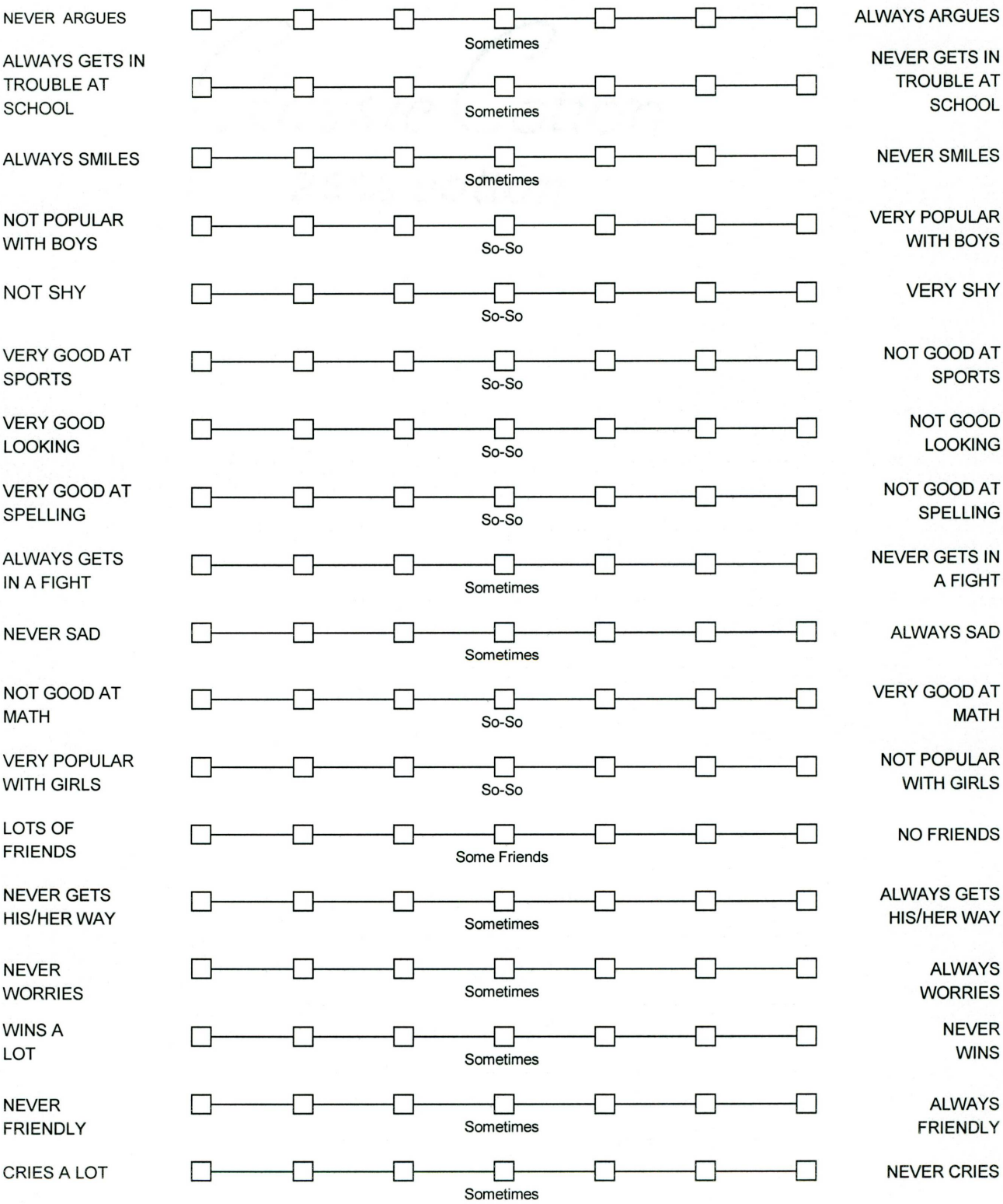
6. I would make a fine model for a new mother to follow in order to learn what she would need to know in order to be a good parent. SA A MA MD D SD

7. Being a parent is manageable, and any problems are easily solved. SA A MA MD D SD

8. A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one.	SA	A	MA	MD	D	SD
9. Sometimes I feel like I'm not getting anything done.	SA	A	MA	MD	D	SD
10. I meet my own personal expectations for expertise in caring for my child.	SA	A	MA	MD	D	SD
11. If anyone can find the answer to what is troubling my child, I am the one.	SA	A	MA	MD	D	SD
12. My talents and interests are in other areas, not in being a parent.	SA	A	MA	MD	D	SD
13. Considering how long I've been a mother, I feel thoroughly familiar with this role.	SA	A	MA	MD	D	SD
14. If being a mother of a child were only more interesting, I would be motivated to do a better job as a parent.	SA	A	MA	MD	D	SD
15. I honestly believe I have all the skills necessary to be a good mother to my child.	SA	A	MA	MD	D	SD
16. Being a parent makes me tense and anxio	SA	A	MA	MD	D	SD

Appendix N (Children)

The Interpersonal Competence Scale



Appendix O

Delinquency Behavior Measure (Children)

Behavior I

Please read each of the following questions and say how often you have been involved in something similar. Circle the number that fits best for you:

		Never	Once or Twice	Several Times	Often	Very Often
		1	**2**	**3**	**4**	**5**
1	Gotten alcohol by asking someone else to buy it for you?	1	2	3	4	5
2	Ditched school without proper excuse?	1	2	3	4	5
3	Gotten drunk?	1	2	3	4	5
4	Stayed out all night?	1	2	3	4	5
5	Broken into someone's house?	1	2	3	4	5
6	Gone for a ride in a stolen car?	1	2	3	4	5
7	Stolen a car?	1	2	3	4	5
8	Taken part in a gang fight?	1	2	3	4	5
9	Carried a knife or other weapon	1	2	3	4	5
10	Stolen things worth $5 or less?	1	2	3	4	5
11	Stolen things worth more than $5?	1	2	3	4	5
12	Set a fire?	1	2	3	4	5
13	Damaged property?	1	2	3	4	5
14	Written on walls, doors, desks, or other places not meant for writing on?	1	2	3	4	5

		Never	Once or Twice	Several Times	Often	Very Often
		1	**2**	**3**	**4**	**5**
15	Hurt an animal on purpose?	1	2	3	4	5
16	Smoked marijuana?	1	2	3	4	5
17	Sniffed glue?	1	2	3	4	5
18	Smoked cigarettes?	1	2	3	4	5
19	Used hard drugs (like crack)?	1	2	3	4	5
20	Sold marijuana or other drugs?	1	2	3	4	5
21	Lied to get out of trouble?	1	2	3	4	5
22	Disobeyed your parents (to their faces)?	1	2	3	4	5
23	Disobeyed teachers (to their faces)?	1	2	3	4	5
24	Shouted at your mother or father?	1	2	3	4	5
25	Cursed your mother or father?	1	2	3	4	5
26	Hit your mother or father?	1	2	3	4	5
27	Shouted at a teacher?	1	2	3	4	5
28	Cursed a teacher or other adult at school?	1	2	3	4	5
29	Hit a teacher?	1	2	3	4	5
30	Ran away from home?	1	2	3	4	5
31	Gotten in trouble with the police?	1	2	3	4	5
32	Picked an argument with someone?	1	2	3	4	5
33	Picked a physical (e.g., fist) fight?	1	2	3	4	5

		Never	Once or Twice	Several Times	Often	Very Often
		1	2	3	4	5
34	Made fun of or teased someone?	1	2	3	4	5
35	Had sex (gone all the way)?	1	2	3	4	5
36	Touched someone's private parts?	1	2	3	4	5
37	Had someone else touch your private parts?	1	2	3	4	5
38	Beat someone up?	1	2	3	4	5
39	Took part in a robbery?	1	2	3	4	5
40	Been suspended from school?	1	2	3	4	5
41	Been expelled from a school?	1	2	3	4	5
42	Almost killed someone?	1	2	3	4	5

Appendix P

Debriefing Statement/Closing Statement

Thank you for your participation in this study. As stated earlier, the purpose for this study is to learn what helps refugees get used to and do well in their new social surroundings after being in a war. It is intended to provide a greater understanding of the services needed to assist persons with refugee status. To be specific, we are interested in finding out how refugee parents' mental health and parenting sense of competence assist in the adjustment of their children. If by answering these questions it results in memories that are distressing, please contact one of the agencies below.

ESSEA Project
6035 University Avenue, #22
San Diego, CA 92115
Dr. Gebaynesh Gashaw-Gant, Program Director
858-829-8735

Survivors of Torture, International
P.O. Box 151240
San Diego, CA 92175
Dr. Crystal Green
619-278-2404

The responses, all of which are anonymous, will be analyzed to compare participants. If you have any questions regarding this study, or are interested in the results and analyses, please feel free contact Nola Lawrence, M.A. at Loma Linda University in the Department of Psychology (909) 558-8577 or Faith McClure, Ph.D. at California State University, San Bernardino in the Department of Psychology (909) 880-5598. You may also write to:

Nola Lawrence, M.A.,

Department of Psychology,

Loma Linda University, Loma Linda, CA 92350

Sincerely,

Nola Lawrence, M.A.

Appendix Q

Languages Spoken for the Study Participants (by number and percentage)

Languages Spoken	Father	Mother	Child
Nuer and English	15 (22.1%)	14 (20.6%)	22 (32.4%)
Nuer	12 (17.6%)	25 (36.8%)	28 (41.2%)
Nuer, Arabic & English	11 (16.2%)	2 (2.9%)	
Arabic	2 (2.9%)	1 (1.5%)	2 (2.9%)
Nuer and Arabic	2 (2.9%)	3 (4.4% each)	
Dinka	2 (2.9%)	1 (1.5%)	2 (2.9%)
Shulluk, Nuer & Arabic	1 (1.5%)	1 (1.5%)	
Bari, Arabic & English	1 (1.5%)		1 (1.5%)
Jurchol		1 (1.5%)	
Jurchol & Arabic	1 (1.5%)		1 (1.5%)
Kakua	1 (1.5%)	1 (1.5%)	
Kakua & Arabic			1 (1.5%)
Lokoya, Arabic & English	1 (1.5%)		
Bari & Arabic		2 (2.9%)	1 (1.5%)
Dinka & Arabic		2 (2.9%)	1 (1.5%)
Dinka & English			1 (1.5%)
Arabic, Dinka & Kakua		1 (1.5%)	
Dinka, Arabic & English		1 (1.5%)	1 (1.5%)
Arabic & English		3 (4.4%)	4 (5.9%)
English, Arabic & Sudanese		1 (1.5%)	
Acholi & English			1 (1.5%)
Missing Data	19 (27.9%)	9 (13.2%)	2 92.9%)

Appendix R

Socioeconomic Information Reported by the Children

	Frequency	Percent
Free Lunch	43	63.2
Reduced Lunch	8	11.8
No Assistance	12	17.6
Total	63	92.6
Missing	5	7.4

Appendix S

Frequency Tables and Histograms of Displacement for Father, Mother, and Children

FATHER

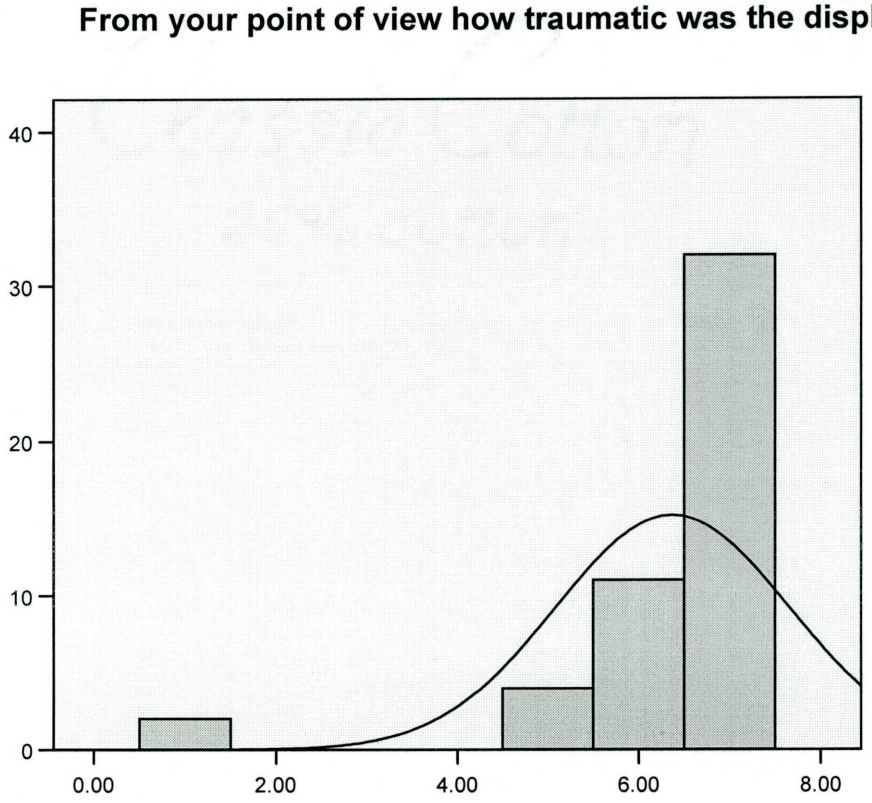


Table 3.
From your point of view how traumatic was the displacement? (Fathers)

Displacement - Father		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Least	2	2.9	4.1	4.1
	5.00	4	5.9	8.2	12.2
	6.00	11	16.2	22.4	34.7
	Most	32	47.1	65.3	100.0
	Total	49	72.1	100.0	
Missing	System	19	27.9		
Total		68	100.0		

MOTHER

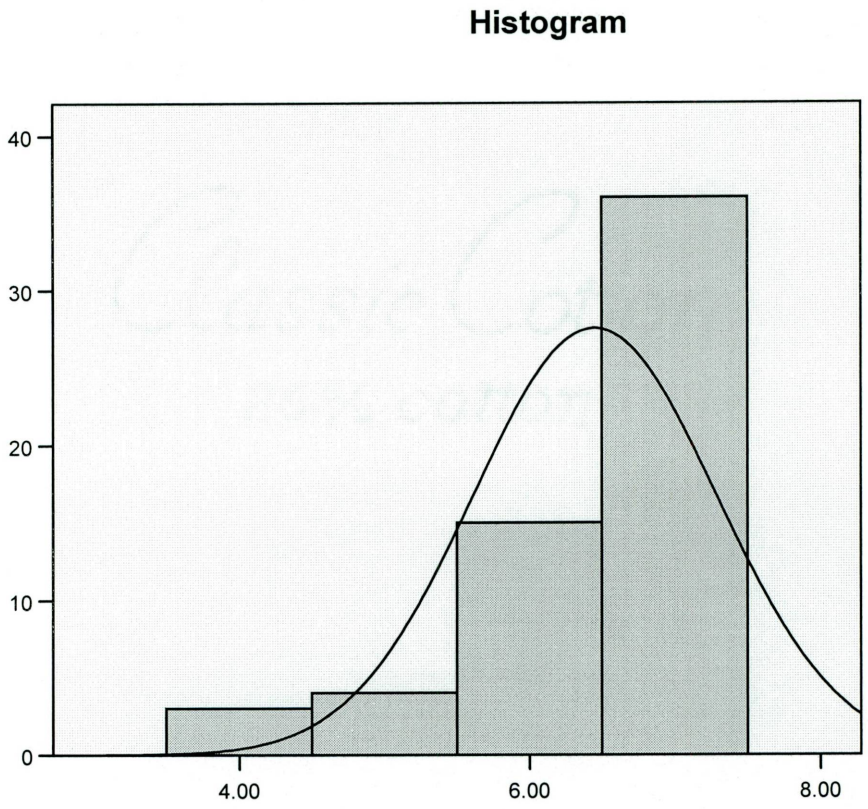


Table 4.
From your point of view how traumatic was the displacement? (Mothers)

Displacement – Mother		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4.00	3	4.4	5.2	5.2
	5.00	4	5.9	6.9	12.1
	6.00	15	22.1	25.9	37.9
	7.00	36	52.9	62.1	100.0
	Total	58	85.3	100.0	
Missing	System	10	14.7		
Total		68	100.0		

CHILDREN

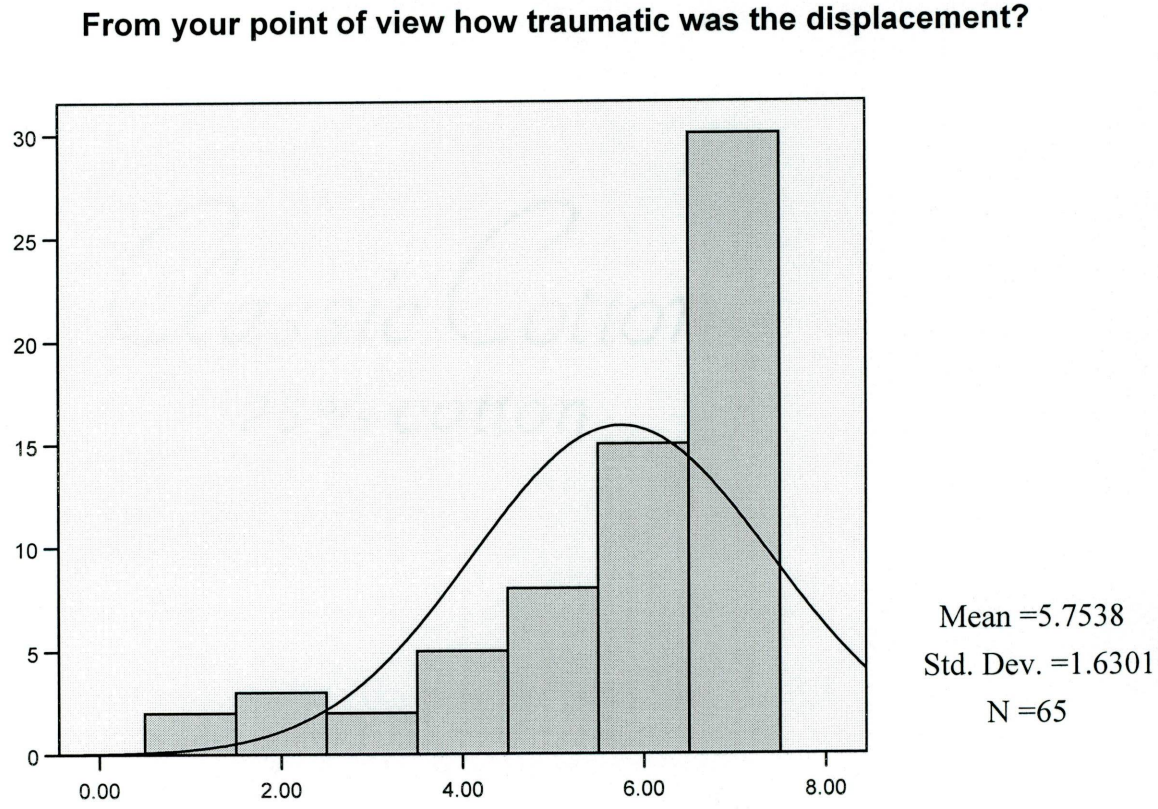
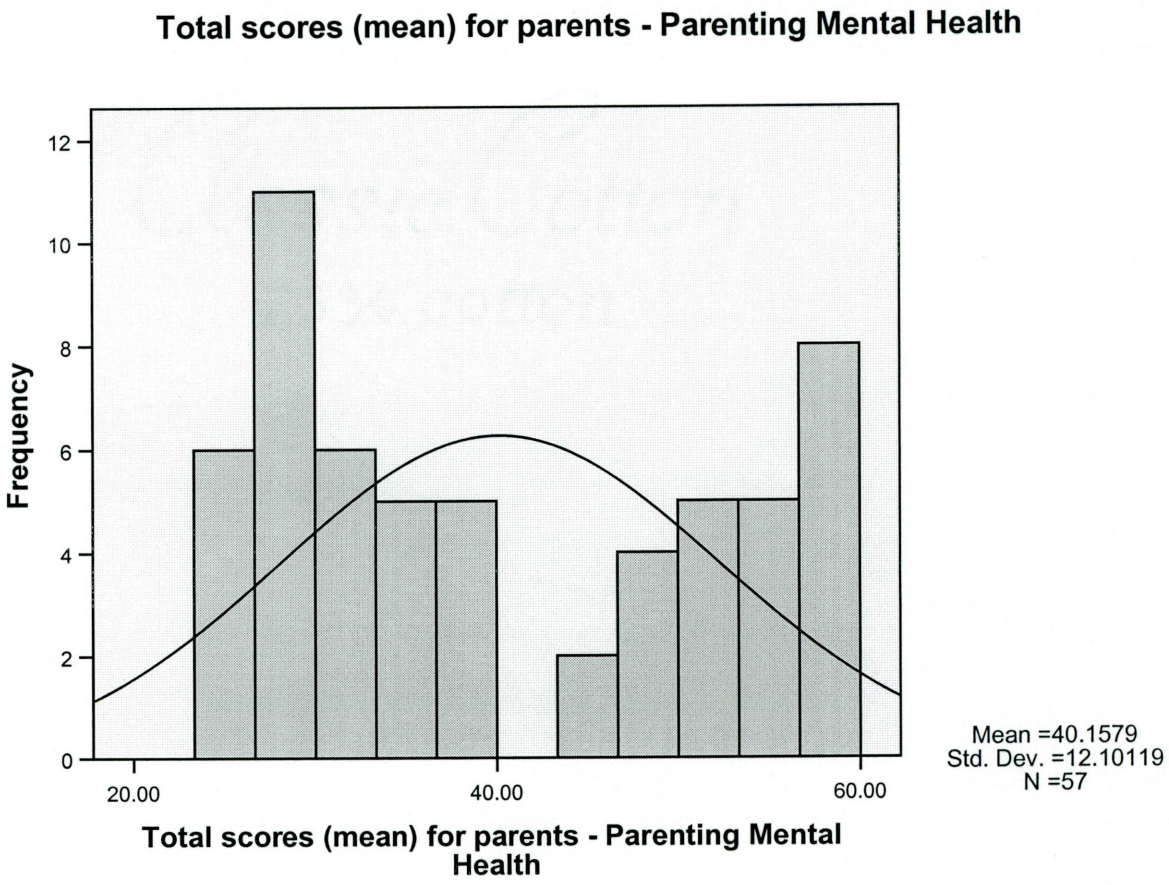


Table 5.
From your point of view how traumatic was the displacement? (Children)

Displacement - Children		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	2	2.9	3.1	3.1
	2.00	3	4.4	4.6	7.7
	3.00	2	2.9	3.1	10.8
	4.00	5	7.4	7.7	18.5
	5.00	8	11.8	12.3	30.8
	6.00	15	22.1	23.1	53.8
	7.00	30	44.1	46.2	100.0
	Total	65	95.6	100.0	
Missing	System	3	4.4		
Total		68	100.0		

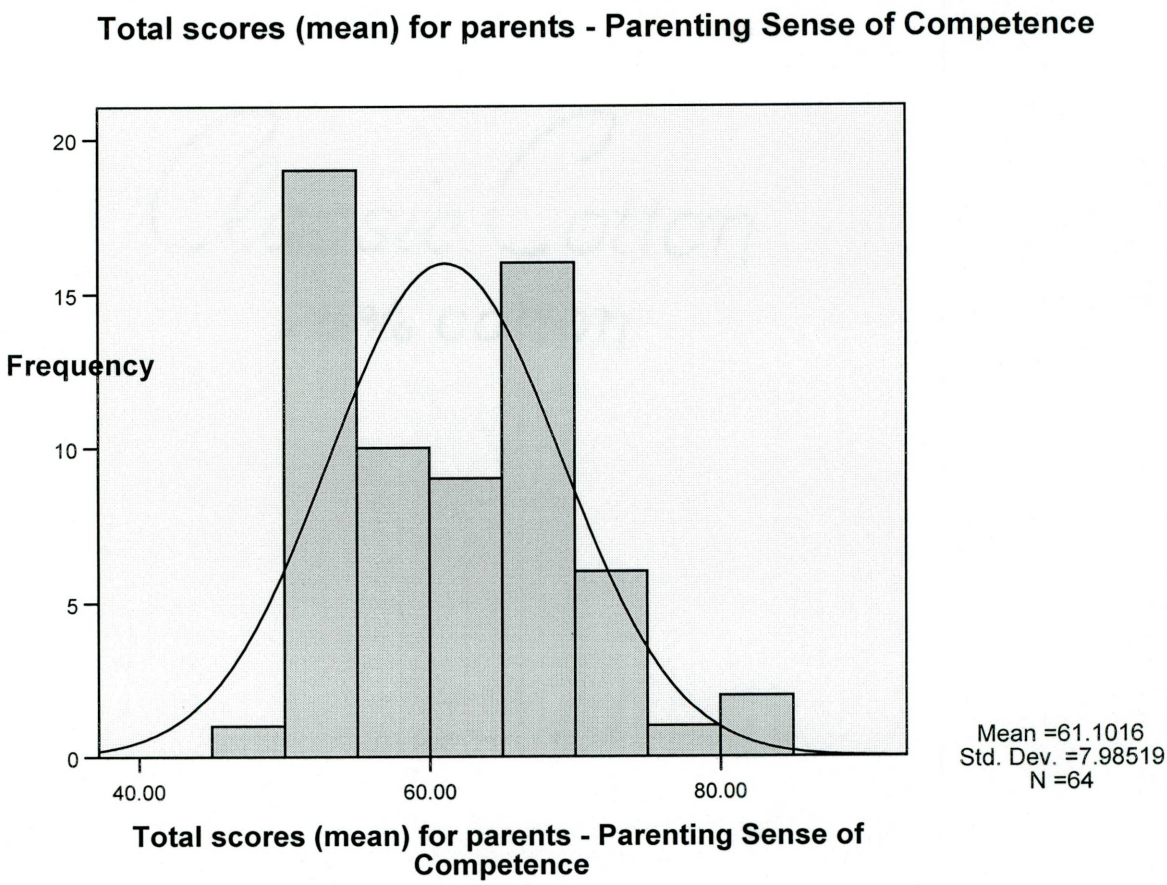
Appendix T

Histogram of Parental Mental Health of the Parents



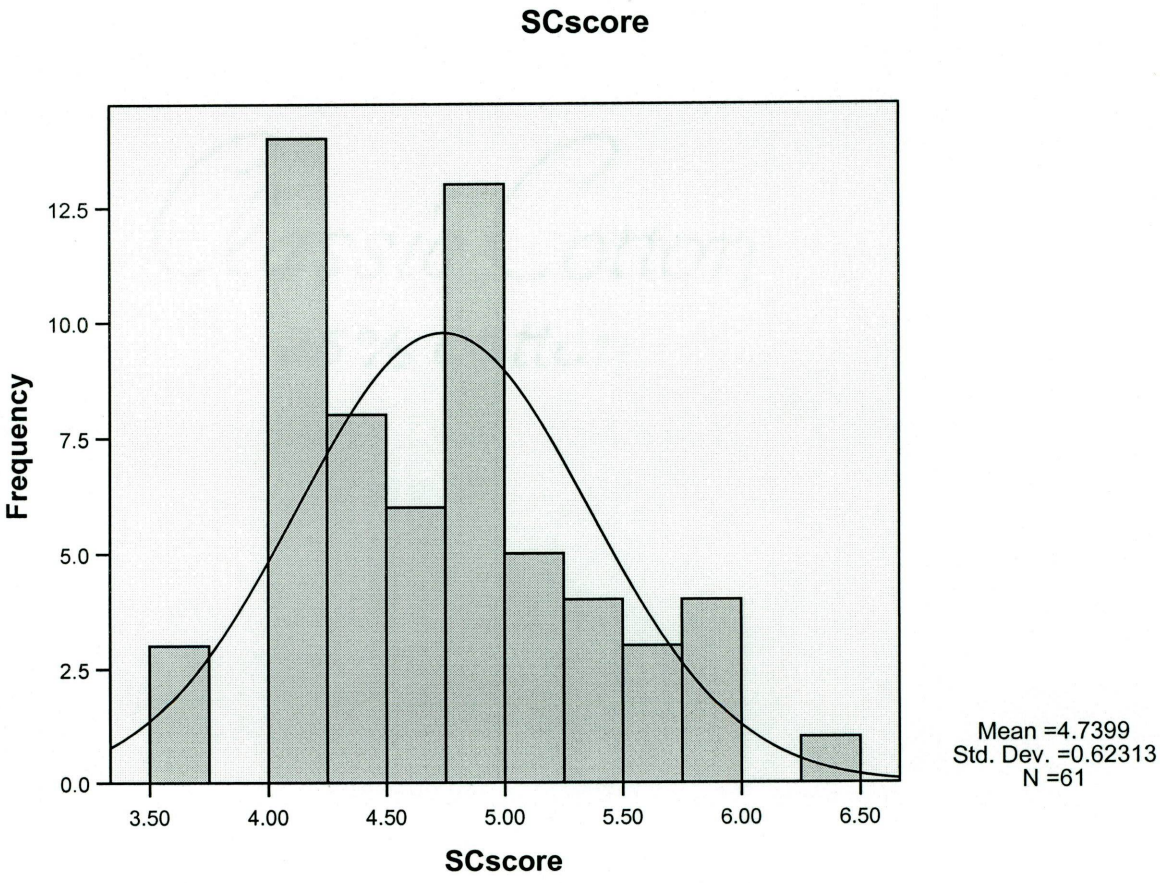
Appendix U

Histogram of Parenting Sense of Competence of the Parents



Appendix V

Histogram of Interpersonal Competence for Children



Appendix W

Histogram of Delinquent Behaviors for Children